Proceedings

National Corrections Conference on Mental Illness

July 18-20, 2001
Boston, Massachusetts

Table of Contents

Executive Summary

The problem:

Managing and treating offenders with mental illness in the prisons

Current statistics from the Bureau of Justice Statistics (BJS) estimate that 191,000 inmates with mental illness are incarcerated in state prisons. This figure comprises approximately 16 % of the state prison population, a rate of mental illness three times higher than that of the general population.

Why are there so many persons with serious or severe mental illness in our Nation's prisons?

According to the experts and practitioners who spoke at the conference, the overrepresentation of persons with mental illness in the criminal justice system can be attributed to a number of historical occurrences which have driven political, social, and policy decisions. The most frequently cited contributing phenomenon was that of deinstitutionalization, which though based on good intention, failed to provide the alternative community-based services it promised and therefore left many persons with mental illness homeless and without services.

There are other policy-driven factors which make it more likely that persons with mental illness will come in contact with the criminal justice system, such as the increasingly punitive drug laws in the country. Persons with serious or severe mental illness often suffer from a co-occurring substance abuse disorder; research has shown that mental illness often predisposes an individual to substance abuse. Another factor cited as contributing to the large population of the mentally ill in jails and prisons is the lack of affordable housing. Because persons with mental illness are also disproportionately represented in the homeless population, they are more likely to be arrested for survival or nuisance crimes. The homeless phenomenon also explains the prevalence of mercy bookings.

Persons with mental illness are overrepresented at every point of contact with the criminal justice system, not only at arrest. They are incarcerated for longer periods of time and they recidivate more often. In addition, the stressful, pathogenic nature of the institution exacerbates symptoms of existing mental illness and can bring out new symptoms in those inmates with a predisposition towards mental illness.

Corrections administrators and staff have been handed an entire population that they are not equipped or trained to deal with. In the past, corrections officers did not receive even basic training in mental health. They were not informed, for example, about strategies for distinguishing between behavioral problems and symptoms of mental illness. Speakers at the conference illustrated that cross-training and cooperative education are becoming widely available, and that barriers to collaboration between mental health and corrections are being broken down rapidly and effectively.

Why have the criminal justice system and mental health providers had difficulty collaborating in the past?

Traditionally, the missions of the criminal justice system and mental health providers were viewed as being at odds with one another. The criminal justice mission was based on public safety, with punishment and "corrections" at its core. On the other hand, the mission of the mental health community was based on public health and viewed as concentrating primarily on treatment. Many stakeholders saw this "conflict in missions" as insurmountable.

In the past, criminal justice practitioners and mental health providers were steeped in different languages and philosophies. They tended to dismiss the importance of the other's mission too easily, and they didn't respect one another's differing perspectives. In the meantime, offenders with mental illness were suffering from the lack of integrated services, the absence of cross-training, and the inadequacy of information-sharing that was the result of the "culture clash" that historically defined the mental health/corrections relationship.

Some innovative minds began to see that overcoming philosophical barriers and collaborating with their "sister" agencies was imperative. The sheer number of inmates with mental illness demanded it. Over the past ten to twenty years, successful collaborations have developed that stress the factors that were previously missing: information-sharing, cross-training, and learning to speak the same language. These collaborations demand that co-workers arrive at the philosophical realization that there is no "conflict in mission"—that treatment is good for public safety, for the individual offender, and for the operational management of corrections facilities.

Conference participants gathered to explore exemplary models of collaboration, to realistically assess present and future challenges, and to implement superior models of cooperation. These strategies are meant to inform and prepare stakeholders and to improve service to public communities, offenders, and states.

First response:

Convene this three-day National conference to promote collaboration, cooperation, and involvement with local communities

Stakeholders held a series of meetings in 2000 to discuss the problem of mental illness in the prisons. The participants all agreed that a valuable first step would be to organize a National-level symposium where important stakeholders could network, study existing best practices, and begin to initiate sincere state-level collaborative efforts. The conference was a response to this suggestion.

Larry Meachum, Director of the Corrections Program Office (CPO), called the conference an "initiation." Richard Stalder, the Secretary of the Department of Public Safety and Corrections in Louisiana, and the conference moderator, described the conference as a "process," rather than an outcome. Planners impressed upon the participants that the conference was meant to be a first step towards ongoing mental health and criminal justice cooperation and collaboration at the state level. An integral part of the event's theme was its demand for a follow-up response at home.

Because planners recognized that the problem of mental illness exists throughout the entire criminal justice system continuum, they attempted to explore of all aspects of the challenge. Speakers and panelists addressed topics that ranged from evaluating, monitoring, and treating the individual with mental illness to planning for an offender's re-entry into the community. The corresponding challenges associated with each stage in the process were also discussed.

Impressive panelists provided valuable information. Planners recruited speakers that articulated the problem clearly and in a way that exhibited their clinical, practical experience, and academic expertise. Sut state teams were asked to do some hands-on work themselves. Each day, state teams were given an hour-long slot to break out into small groups with pre-designed state planning guides. These guides were used as models to help teams develop detailed plans for future collaboration and cooperation at the local level. At the start of the conference, states chose team leaders. These leaders were elected to direct the efforts back home to continue the collaborative "initiation" that began at the conference.

The planners wanted to achieve the following three goals from the conference:

1. Provide education, information, and networking resources so that stakeholders could make informed decisions about offenders with mental illness in corrections.
2. Promote and improve intra- and inter-agency coordination and cooperation.
3. Encourage and support state teams in developing their own symposia on mental illness in the criminal justice system. These symposia should include the stakeholders who were not involved in the National conference, including those involved with mental illness in the juvenile justice system, those working with the jail population, and those who work primarily with offenders who have co-occurring disorders.

The mission statement of the conference sums up the scope and goals of the planning efforts:

To promote public safety, public health, institutional order, and best resource management through the coordination and collaboration of corrections and mental health agencies in effectively identifying, treating, and monitoring offenders with

An outline of the conference:

Day-long themes

The three-day conference was broken down into day-long themes. A brief description of each day's theme and format follows.

Day one—defining the scope and nature of the problem and exploring policy issues

The following topics were addressed within the context of Day one's focus:

- **Providing an overview—the keynote speech.** Dr. Fred Osher, Director of the Center for Behavioral Health, Justice, and Public Policy at the University of Maryland, gave the conference keynote speech, which provided an overview and background of the problem of offenders with mental illness in the prison system. This speech provided a context for conference deliberations.
- **Presenting the most recent statistics.** Dr. Allen Beck, Chief of the Corrections Statistics Program, BJS, provided a summary of the most recent statistics for those in the prison system with mental illness. These statistics provided a numerical picture that participants could use throughout the conference to understand the scope of the problem. Dr. Bonita Veysey and Lucille Schacht joined Dr. Beck in presenting telling statistics about a study that researched the use of medications in prisons and jails. These numbers helped illustrate the trends in medicine use, including the use of traditional versus new generation medication and what effect that had on formulary and algorithm decisions. Their study also addressed staffing issues, which could be of use for facilities as they develop service plans.
- **Managing and treating the growing number of offenders with mental illness in the prisons—a panel called *The Challenge*.** A group of panelists representing the front lines of corrections spoke about the challenges posed to prison management and practices. The group focused on inmate safety, what services are provided, and how cross-training changes attitudes and improves overall prison management and outcomes for individual offenders with mental illness.
- **Advocating for the mentally ill.** Carla Jacobs of the National Alliance for the Mentally Ill (NAMI) provided the perspective of an advocate. She relayed a personal story about a tragedy that occurred when a family member became non-compliant and decompensated. She discussed policy issues and societal attitudes that affect how our country treats the mentally ill.
- **Owning the problem—a panel called *Yours, Mine, or Ours?*** This panel brought together stakeholders from mental health, corrections, and the legislature to discuss the responsibilities of different agencies for identifying, treating, and monitoring offenders in institutions and in the community. The panelists all agreed that the problem was "ours"—no one agency could alone handle the complexity of the problem. The only solution was to learn to create effective collaborative strategies tailored to local community needs.
- **Reviewing current practices—state team breakout.** State teams got together and reviewed their state's current practices for identifying, treating, and monitoring offenders with mental illness. They also identified barriers to intera-gency collaboration such as the sharing of information; training; funding; and the understanding of relevant legal issues, policies, and procedures. They identified state needs and appointed a team leader, who is to be responsible for coordinating state team efforts back home.
- **Considering legalities—laws, litigation, and their effect on the problem.** Stakeholders, including a legislator, a corrections commissioner, an advocate for the mentally ill, and a state mental health agency's counsel identified legal trends and recent court decisions that are affecting persons with mental illness in the prisons.

Day two—exploring treatment options and best practices

The following topics were addressed within the context of Day two's focus:

- **Summarizing the state of the research—Evidence Based Practice.** Dr. Robert Drake, a well-known clinician and researcher, spoke of the movement towards Evidence Based Practice in the mental health community. This movement is based on the idea that treatment should evolve from empirical data, not from theoretical speculation. Evidence Based Practices that have been widely accepted in the mental health community as the cornerstones for effective services include medication, supported employment, and Assertive Community Treatment (ACT).
- **Asking how research should inform policy—a panel called *Science and Policy*.** Panelists discussed the importance of including the academy in collaborative efforts. They discussed current trends in psychoactive medication, the advent of telemedicine, and Evidence Based Practice interventions that are producing successful outcomes.
- **Hearing the perspective of corrections mental health directors.** A group of state corrections mental health directors discussed the need for a standardized assessment tool to evaluate the severity of mental illness and of the need for collaboration among directors.
- **Offering his support—Senator Edward M. Kennedy.** The Honorable Edward M. Kennedy joined the conference via video, pledging his support for the issue of mental illness in our Nation's prisons, and congratulating participants on their commitment to work together to best manage the complex challenge.
- **Exploring best practices—a panel called *Effective Collaborations*.** This panel brought together a group of stakeholders who have established innovative, effective corrections/mental health collaborations in their states. Examples include a legislative task force that was established in Colorado, a working group focused on the issue in Massachusetts, and a state agency that oversees and monitors continuity of care for offenders with mental illness in Texas. These efforts can serve as models for states that are not as far advanced in their collaboration.
- **Planning for collaboration—state team breakout.** State teams began to plan for improved cooperation in their states, drawing on the information they had garnered so far from the conference. Teams talked about how they could model their programs after those discussed in "Effective Collaborations," and about how they could incorporate research findings into their policies and practices.
- **Presenting testimony from the Council of State Governments (CSG).** The CSG is a non-partisan, non-profit organization dedicated to developing detailed, bipartisan recommendations for improving the criminal justice system's response to individuals with mental illness. The panelists spoke of the

mission of the CSG and of the importance of including all stakeholders in collaboration, including, importantly, law enforcement and the courts.

- **Examining best practices for predicting successful re-entry—a panel called *Assessing Risk upon Re-entry*.** Panelists discussed the importance of encouraging offender responsibility, getting more accurate information so that practitioners can better predict risk, and including community assessment when developing tools and protocols.

Day three—re-entry of offenders with mental illness back into the community

The following topics were addressed within the context of Day three's focus:

- **Looking at best practices—a panel called *Re-entry that Works*.** Panelists discussed the importance of encouraging and monitoring medication, networking in the community, and providing integrated systems for offenders with co-occurring disorders. They also discussed elements critical to successful re-entry such as housing, supported employment, and training.
- **Planning for re-entry—state team breakout.** State teams discussed how they could best assist in the re-entry of offenders with mental illness back into the community. Teams set some long-term and short-term goals, which could include planning a state symposium for criminal justice system and mental health service agencies.
- **Understanding funding for inmates with mental illness—a panel called *Accessing Federal Entitlements.*** Panelists provided general guidelines about accessing Federal funds, but urged conference participants to develop relationships with their local Social Security, Medicaid, and Medicare offices to better develop locally tailored plans for accessing Federal entitlements.

Participants:

State and territory teams representing jurisdictions across the Nation

The conference was sponsored by the Department of Justice (DOJ), the Office of Justice Programs (OJP), and the Corrections Program Office (CPO). States and territories were invited to assemble their own teams of 11 participants. It was their responsibility to choose the persons they felt would benefit most from attending the conference and who would be able to bring the conference information back to other stakeholders in their state. All 50 states and a number of territories were asked to participate. Team membership varied, but many included the following:

- State corrections administrators

- State corrections mental health administrators
- Directors of state mental health agencies
- Directors of state substance abuse treatment agencies
- Representatives from the judiciary
- Representatives from the Governor's office
- Legislators
- Representatives of state criminal justice agencies
- Representatives from the state's housing, labor, or education agencies

These teams were expected to take their knowledge home and include other stakeholders at the local level whose area of expertise had not been addressed at the conference. State-level collaborative efforts should include, for example, those dealing with special populations such as juveniles, sex offenders, tribal populations, or inmates with co-occurring disorders; different locales such as jails; individual stakeholder groups such as prosecutors.

General recommendation for the future:

Continue education, identify best practices, and promote innovative collaboration among agencies and stakeholders involved in identifying, treating, and monitoring inmates with mental illness

The conference was meant to be a catalyst that encouraged collaboration among state-level agencies and improved coordination and cooperation within and among those agencies. States are expected to continue their efforts by planning and organizing for continued and improved coordination, cooperation, and collaboration. They were encouraged to develop a consensus for action by reaching out to additional planning group members at the local level and by planning a state symposium.

Specific recommendations for the future:

1. **Hold state-level symposia.** States are expected to plan for and hold state-level symposia that include the stakeholders who were not included in the National conference, such as those involved with mental illness in the juvenile justice system, those working with the jail population, and those who work primarily with offenders who have co-occurring disorders. State teams were provided with planning guides that offered suggestions and skeletal, generic instructions for beginning this process.

2. **Use Federal resources when planning for state symposia.** The Federal government has started the impetus to get the ball rolling in all 50 states and territories. CPO will continue to monitor progress and will assist

states in moving forward by publishing relevant information and promoting communications among states and territories.

3. Include strategies for publicizing the issue and the needs it creates in future conferences. Conferences need to be held not only to further cooperation and collaboration among stakeholders, but also to strategize about how to "get the word" out about the problem of mental illness in the prisons in a way that captures and secures resources.

4. Develop a standardized assessment tool. Many speakers and panelists spoke of the need to develop standardized assessment tools that are intended to accommodate inmates with multiple diagnoses. The tools, designed to meet the complex needs of the inmate population, need to be developed and tested so that inmate treatment can be based on reliable diagnoses right from the start.

5. Create relationships with local Social Security and other entitlement offices. Many participants had specific questions about how Federal entitlements could be used to address the particular needs of offenders in their jurisdiction. The valuable advice given was to develop relationships with local offices and to work with them to develop state-specific entitlement practices.

6. Work to clarify the issue to the media and to dispel myths associated with mental illness and violence. A number of panelists and speakers told of their interaction with the media in answering questions about mental illness in the prisons and about the apparent connection between mental illness and violence. Conference participants were urged to educate themselves about the subtleties surrounding the issue, so that they would be able to articulate the complexities involved in the relationships among mental illness, incarceration, and violence.

7. Explore emerging technology such as telemedicine, that will allow wider provision of services in prisons.

Of the new technologies discussed throughout the conference, telemedicine was most widely cited. It was suggested that telemedicine could offer a partial remedy to the current shortage of services, especially in prisons located in rural areas where access to psychiatric care is geographically difficult.

8. Use Evidence Based Practice research when implementing plans.

Certain interventions are backed by evidence that illustrates their effectiveness. The newest world-wide medical "movement" is the Evidence Based Practice movement, which promotes the use of standardized treatments that are tested through objective outcome measures. These treatments rest on principles that can be tested, rather than on dogma. Some Evidence Based Practice interventions, such as supported employment, have been shown to significantly improve successful reintegration into the community for persons with mental illness.

Day one
July 18, 2001

Theme

Defining the scope and nature of the problem and exploring policy issues

Welcome—*Larry Meachum*

Speaker

Conference Sponsor
Larry Meachum
Director
Corrections Program Office (CPO)

Welcome to great interdisciplinary teams from the country's states and territories

Larry Meachum welcomed all on behalf of the Attorney General, the Department of Justice (DOJ), the Office of Justice Programs (OJP), and the Corrections Program Office (CPO). He described the conference as an invitation-only policy conference, like many other conferences and special events sponsored or co-sponsored by CPO. Examples of such past events include the National Symposium on Drugs, Alcohol, and Crime and conferences that have addressed such issues as female offenders, interventions with violent offenders, prison privatization, and violent youths who are tried as adults.

***Summary*:**

CPO Director Larry Meachum welcomed all participants and described the history of the conference and its goals. He offered Federal aid and guidance to states as they begin to develop local collaborative plans. An important theme of the conference was collaboration, as illustrated

CPO assembled cross-agency, cross-disciplinary teams that would help each state and territory comprehensively address its own needs. Teams were expected to go back home and work in concert to solve the problem in their home jurisdictions.

The conference organizers recognize that the problem is complicated and must be examined as an issue that affects at least the following four areas of government and society:

- Public safety
- Public health
- State resource management
- Institutional management

Who made up the state teams?

Teams generally included:

- Legislators (one from the House and one from the Senate)
- Agency heads
- Interested state policy makers from different levels
- Practitioners

Why look at mental illness in prisons?

The conference topic grew out of focus groups held for state correctional administrators in Chicago and Denver in the spring of 2000. The number one interest and concern expressed by administrators was the problem of the mentally ill offender in prison.

The conference looked at the problem from two perspectives by exploring best practices for:

1) Dealing with individual offenders
2) Managing the problem from an operations perspective within the prison environment

"What we've done is we've come together and said is there a problem? And do we need to do something about it? Regardless of the past, are we doing what should we be doing? And what should we do

New questions that foster respect and collaboration

Because states have limited resources, in the past corrections and mental health agencies have held the view that they had a conflict in missions. The two disciplines often asked questions as: *Are we doing the right thing? Are we coming from the right place? Do we have the right motives? Do we have the right expertise? Are they giving us a job that is not ours?* Mr. Meachum attempted to move forward from these questions and propose new questions that encourage collaborative solutions.

Conference development a team effort

In the spirit of collaboration and cooperation, conference planning was a joint effort among many government groups, associations, and agencies. In order to develop the agenda, CPO worked closely with the Department of Health and Human Services (HHS), the Council of State Governments (CSG), other organizations within DOJ—including the National Institute of Corrections (NIC) and the Bureau of Prisons (BOP)—many mental health agencies, all state correctional mental health directors, and various associations. It was critical that all were involved in the planning process. The agenda was compiled to meet the needs of both the corrections and the mental health communities.

"Initiation" means that this will not be the last time teams will be working with the problem of identifying, treating, and monitoring inmates with mental illness at every point in

Goal of the conference is to be a problem solving "initiation"

Planners envisioned the conference as an "initiation," which means that the work does not stop when the conference ends; it is meant to promote ongoing cooperation and collaboration at the state, Federal, and local levels.

Conference focus is adult offenders with serious mental illness

Teams of 11 persons who are affiliated with the adult prison population were invited by each state. The conference did not deal with juvenile corrections, jails, co-occurring disorders, character disorders, or sex offenders. Planners chose to focus primarily on the seriously mentally ill in prison. While all issues were not covered at the conference, planners hoped teams will address these groups when they return home.

Teams were meant to think about implementation strategies for their jurisdiction throughout the conference, strategizing about ways to go back home and deal with the problem at a local level.

"We never want to be directive to you; we want to make sure that we give you information for informed decision-making and to help you pursue best practices, but after that you have to

The Federal government offers aid to states in addressing this problem

The Federal government will assist states within the resources available without taking any of the autonomy from the states in designing their own plans. The Federal government does not want to tell individual states what their strategies should be. Mr. Meachum offered assistance for state-level symposia, which will ideally include the topics not discussed at this conference, such as jails, juveniles, tribal groups, cross- cultural/cross-gender groups, and include stakeholders who are not fully represented at this conference, such as prosecutors, and those.

Mr. Meachum offered to broker networking services, research materials, and guidance about who should be at the table, but placed ultimate faith in the state-level leadership to develop a plan tailored to local needs.

Welcome—*Richard Stalder*

Speaker

Conference Moderator
Richard Stalder
Secretary
Department of Public Safety and Corrections, LA

Ultimate conference goal is to provide an opportunity for education

Richard Stalder stressed that the conference is part of an educational process; it is not, in itself, an outcome. The planners are hoping, however, that it will fuel a very positive outcome. What the planners are expecting of the participants is that they take what they learn in this room, take what they get from interaction with their peers around the country, take what they get from their planning sessions here and back home, and ultimately fashion correctional systems that provide appropriate and adequate services to mentally ill offenders.

Richard Stalder's restatement of the mission of the conference:

"We're here to promote the coordination and collaboration of corrections and mental health agencies in effectively identifying, treating, and monitoring offenders with mental illness who are sentenced to or released from state correctional facilities, in a

Mr. Stalder introduced and emphasized the themes for each of the three days, which were:

Day one: Exploring policy issues, exploring the problems, exploring the challenges. What is it exactly that stands in the way of our providing these kinds of services?

Day two: Exploring treatment options, exploring best practices, exploring how to meet these challenges.

Day three: Exploring re-entry of offenders with mental illness coming back into communities. How do we provide for continuing treatment? How do we provide for continuing medication? How do we provide resources?

Opening Remarks—*Mary Lou Leary*

Speaker

Mary Lou Leary
Acting Assistant Attorney General,
Office of Justice Programs (OJP)
U.S. Department of Justice (DOJ)

We have come a long way over the past few years but still have a long way to go

Mary Lou Leary welcomed the group and told them that this issue has become increasingly critical to the safety and well being of our communities. She presented research and statistics to underscore the seriousness and relevance of mental illness in the criminal justice system.

Summary:

There have been many positive developments over the past few years in the attempts to deal with offenders with mental illness in the criminal justice system. One of the most promising steps forward is the ongoing and growing collaboration between criminal justice and mental health practitioners and the realization that both have a lot to learn from the other. Numbers measuring the availability of treatment in prisons are promising, but there is still a tremendous

The Bureau of Justice Statistics (BJS) reported that about 16% of inmates in our Nation's state prisons suffer from mental illness; this means there are an estimated 191,000 individuals "in agony." Many researchers have also documented the link between mental illness and crime.

Ms. Leary discussed the broadening perspective of the criminal justice system. As the U.S. Department of Justice (DOJ) has been examining the impact of mental illness in communities, it has come to realize that the criminal justice system simply does not have all the answers for how to best respond to mentally ill offenders. Many offenders have mental health needs that the criminal justice system can't meet.

Also, DOJ recognizes that it's not just a public safety issue, though this aspect of the problem is vitally important. The problem must also be looked at from the mental health and public health perspective as well. It is the job of conference participants to identify a broad range of services and resources so that they can effectively identify, monitor, and—where appropriate—sanction mentally ill offenders.

For the past several years, DOJ has been working very closely with the Department of Health and Human Services (DHHS), pooling their knowledge and their resources for dealing with mentally ill offenders. When DOJ held its first joint conference with the Center Mental Health Services (CMHS), one overwhelming recommendation came out of the meeting: that groups come together and conduct events such as the current conference. These gatherings allow teams to share information and encourage collaboration between corrections, mental health, and drug treatment practitioners at state and local levels.

Ms. Leary stressed that communities have come a long way in the last few years in addressing the problem of mentally ill offenders in our Nation. One very positive advance is that the mental health and criminal justice systems are actually working together to find solutions to the problem. Everyone is

recognizing that they have much to learn from one another. Through mutual discussions, the criminal justice practitioners have come to understand more about the mental health system, and the mental health practitioners have come to realize that many of their clients already are, or inevitably will be, in the criminal justice system and will come under correctional supervision.

Putting a face on the problem

Ms. Leary relayed a recent story published in the *Washington Post* about Helen, a woman with mental illness, who bounced around for years between the criminal justice system and community mental health systems. Because she had mental illness, she had serious problems with other inmates and was barred from shelters in the city because of her erratic behavior. She finally attacked a passerby in order to get some help, and got what she needed from a new, integrated program in the city.

Six months after being released from the program, Helen has stable housing, has not been re-arrested, and is looking for a job.

Ms. Leary assured the audience that they would hear more success stories and offered statistics that show progress in the amount of mental health services that are available in jails and prisons.

Though the data shows progress, it also shows that corrections and mental health have a long way to go, if they want to make sure that every inmate is screened, gets appropriate treatment, and is connected to follow up services in the community.

Opening Remarks—*Dr. Bernard Arons*

Speaker

Dr. Bernard Arons
Director
Center for Mental Health Services (CMHS),
Department of Health and Human Services (HHS)

A lot of good things are ready to happen

Dr. Bernard Arons introduced himself, saying, "I'm supposed to provide the voice of the mental health community."

He stated the mission of Center for Mental Health Services (CMHS), which is " to improve the services needed by Americans who have mental disorders." Because caring for the Nation's mental health is the Center's passion, this means that a lot of its concern must focus on the Nation's jails and prisons.

"It is sometimes said that the largest mental institutions in the United States are now places like Rikers Island in New York or the LA county jail. On any given day 300,000 Americans in prison with serious mental disorders are incarcerated in

Three approaches to providing improved care require systems change

Dr. Arons introduced the three approaches that are currently being explored as a means to providing mental health care in the criminal justice system:

- Divert offenders from jail to community services.
- Find ways to provide quality mental health services within corrections services.
- Develop and implement plans to provide services upon offender's release so that the cycle of recidivism is broken with effective accessible mental health services outside of prisons.

"I don't think I'm being over optimistic to say that system change is starting

To implement these approaches, all the stakeholders need to think about systems change. Dr. Arons urged the conference participants to make a commitment to change.

We know how to solve this social problem—treatment works

Society doesn't always have a proven answer when dealing with difficult social problems. However, Dr. Arons pointed out that we do know what to do concerning the issue of mental illness in the prisons.

Studies and clinical work have shown that treatment reduces criminality. Stakeholders must put that knowledge to work.

Signs of positive change

In 1997, the CMHS joined with the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), for a three-year study of jail diversion programs (pre-booking and post-booking) for offenders with co-occurring disorders. The study is finishing up now and has received an enthusiastic response, which illustrates a growing interest in mental health treatment alternatives. From the beginning, there were inquiries from practitioners in the criminal justice system, asking to use study sites as models in their jurisdictions.

The mental health community was also very pleased to hear of the recent $80 million re-entry grant program of the Young Offenders Initiative. The grant will support the development of re-entry programs for young people with mental health or substance abuse problems who are returning to the community.

"The goals of corrections, mental health, and substance abuse treatment are all achieved through treatment. There is no

Another positive sign related to this grant is the collaborative efforts that produced it. The Department of Health and Human Services (DHHS), DOJ, and the Department of Labor (DOL) all worked together to create the grant program. There have been quite a few examples of people coming together to solve problems over the past few years. People who were not willing to work together before are achieving consensus and seriously addressing the problem of mental illness in the criminal justice system.

The knowledge is there, and support in Congress is there: there are several new bills on jail diversion and corrections treatment coming up for review. The necessary partnerships are beginning to come together.

Key to successful partnership is mutual respect

Because mental illness can affect so many aspects of a person's life, the Center for Mental Health Services (CMHS) at SAMHSA has been developing and managing programs in partnership with other agencies. The organizations have learned a vital lesson about partnership—there must be mutual respect. Never mind who did what wrong in the past, never mind assigning blame. The more one respects the other's good will, expertise, and mission, the more successful both organizations will be in achieving their goals. There used to be a perceived conflict—do we spend money on treating offenders or on keeping them behind bars so the public will be safe? ***There is no conflict.*** Success at solving the many problems associated with mental illness in the prisons depends on mutual respect, which continues to grow.

" In sports they often talk about keeping your eye on the ball. Maybe that metaphor will serve us in our deliberations here. The ball is not our agency operations manuals; it is not about us at all; it is about those individuals on Rikers Island and in prisons all across America who are struggling with mental illness, substance abuse addictions, and often both. Our margin of victory will be the extent to which we identify and remove the

Commitment is evident

Why hope? One reason is the obvious commitment of conference participants—important decision-makers and policy makers attended the conference to show support for their states and disciplinea. Dr. Arons pointed out one person who exemplifies this commitment—Charlie

Currie—recently named the Administrator of SAMSHA. In spite of his new duties, Mr. Currie attended the conference, representing Pennsylvania as a state.

Keynote Address—*Dr. Fred Osher*

Speaker

Fred Osher, M.D.
Director
Center for Behavioral Health,
Justice, and Public Policy
University of Maryland

Overview and background of the problem of offenders with mental illness in the prison system

Key themes:

1. ***Overview of scope of the problem*--why are there so many persons with mental illness in the criminal justice system?**
2. ***Define who we're talking about when we speak about the mentally ill*—Mental Health 101—we need to narrow our focus.**
3. ***Define who we're not talking about*—we don't have the resources to address all folks with all mental conditions. We must do the best we can with limited resources available.**
4. ***Briefly describe the history of mental health treatment in the country* and where we may be going.**
5. ***Outline continuum of***

Dr. Fred Osher explained his role as providing an overview and a context for conference deliberations.

Putting a human face on the problem—Helen's story

To put a human face on the problem, Dr. Osher described Helen, a woman he met at Health Care for the Homeless (HCH) in Baltimore, Maryland. By beginning with Helen's story, Dr. Osher aimed to keep the focus of the discussion on the real reason for the conference.

Helen is a 35 year-old African-American woman who was referred to HCH by the YWCA, when staff noticed that she was acting strangely and exhibiting disruptive behavior. She told her story to Dr. Osher.

Helen had recently been released from state prison after spending 14 years behind bars. At age 19, she had been convicted of murdering her stepfather who had been sexually and physically abusing her since she was five. She started doing speedballs (a combination of heroin and cocaine) at age 15 on the streets of Baltimore as a way of dealing with anger.

During her prison stay, she developed a set of symptoms consistent with mood disorder, which is not uncommon for persons who stay in prison for a long time. She had ups and downs in behavior, was isolative some of the time, euphoric at others, talking all the time, and not sleeping.

She was diagnosed with bipolar disorder and prescribed lithium. Her symptoms resolved. Helen was able intermittently to get heroin on the inside, and maintained a marginal-level opiate habit.

Helen was released to Baltimore City streets with the modal discharge planning of our day. She had no money; she had a prescription, but no medication to take, and no housing. Helen was essentially left to her own resources. However, she had plans—she wanted to get into methadone treatment, and

return to a clerical job she had enjoyed; she wanted to stay away from drugs, knowing the lure in city was more than she could handle. While panhandling to survive, she was accosted, stabbed in the stomach, and taken to a local hospital where she received an emergency hysterectomy. Ironically, she was then eligible for a transitional housing program at the YWCA for homeless women who were recovering from medical conditions.

" What a terrible outcome.

A woman who, in order to end her years of abuse, had to shoot her perpetrator.

Who, in order to get housing, had to be stabbed in the abdomen.

Who, in order to get mental health treatment, had to be off medicines long enough that any of us would diagnose her as having a mental disorder.

Who, in order to get drug treatment, felt she had to artificially use in order to get into a program.

The staff noticed that Helen was talking to someone not there, appeared paranoid, was not taking care of her wounds, and was not sleeping. It was at this point she was referred to HCH.

When she saw Dr. Osher, her goals were less clear—she wondered if she really belonged behind bars. She was no longer sure that she was ready for community living.

Helen continued to be determined to get into methadone maintenance. She had heard that to get one of the few available methadone slots in Baltimore City, you had to be actively using. She shot heroin and asked her parole officer to try to advocate for her entrance into methadone maintenance.

Several weeks after she saw Dr. Osher, Helen was arrested for possession and sales, and for violating parole. She is now back in the state prison system.

Scope of the problem—how many persons with mental illness are in the criminal justice system?

" Unfortunately, this is not a random slice of people in our country. Persons of color are vastly overrepresented at every stage of the justice continuum, and

Dr. Osher posed the question: "How large is the problem?" There is a sense that this is not a trivial issue, as illustrated by the following statistics. In 1990, 1 in 218 United States citizens were incarcerated. In 2000, one in 142 are incarcerated. There are over two million persons in our prisons and jails, and four million on probation or parole. Three percent of the U.S. population is under correctional supervision, which is the largest per capita percentage of any country in the world.

A previous Bureau of Justice (BJS) study, using survey methodology, showed that 16% of state prison inmates, local jail inmates, and probationers reported that they had been treated in the past for emotional disorders. Considering that other data shows that everyone who has a mental illness doesn't necessarily get treatment, these figures may be low.

" Just as the stigma, fear, and discrimination affect the response of corrections people to offenders with mental illness, so too the stigma, fear, and discrimination affect the response of mental health systems to persons with criminal backgrounds."

The rates of serious mental illness among the incarcerated are nearly three times higher than in the general population. Almost 75 % of those with mental illness also have a co-occurring substance use disorder.

It is important to also recognize that transinstitutionalization is not just a phenomenon of moving from clinical to correctional settings. It is a two-way street. There is also a prevalence of criminal justice histories in mental health settings. A recent study of New York State psychiatric facilities showed that approximately 25% of the men and 15% of the women had been incarcerated at least once in the year prior to their hospitalization.

Five reasons Dr.Osher cited explaining why there is a disproportionate number of persons with mental illness in our prisons

1. Persons with mental illness are arrested at disproportionately higher rates than person without disorders.

Why is this? There are two big contributing factors.

Because of co-occurring substance related-disorders.

In general, the ballooning jail and prison populations can be directly linked to increasingly punitive sanctions for the possession and sale of illicit drugs beginning with the Anti-Drug Abuse Act of 1988. We also know from some fairly good methodological studies done in the mental health field that the presence of mental illness triples the risk of a person having a co-occurring substance use disorder. This is no random association. There is something about having a mental illness that makes someone more vulnerable to substance use disorder. This frequent co-occurrence results in an individual with mental illness:

" Six out of ten persons with mental illness report being high when they committed their

- Committing more violent crime
- Being incarcerated because of our country's current drug policies

We need to acknowledge the complexity of the mental illness and violence association. The issue has more myth than fact commonly cited. However, if

you have serious mental illness, there are several features that will increase the likelihood of violent behavior:

- A history of violent behavior
- Non-compliance with psychotropic medication
- Co-occurring substance disorder

" Considering the general population, serious mental illness is rare and violent crime is rare and the two rarely co-exist. Therefore, it is fair to conclude, despite high profile stories in our media, that the contribution of mental illness to overall violence in this country is

A recently released MacArthur violence risk assessment study, which was methodologically improved over previous studies, found that violence goes up with substance abuse in both general population and in the population that has mental illness. Because persons with mental illness generally have more substance use, this substance abuse goes a long way in explaining the slightly higher rate of violence among individuals with mental illness and their more frequent arrests.

Because jails and prisons often become housing of last resort in this country. When law enforcement is faced with inadequate, insufficient community services, and residential options, we are faced with mercy bookings. You have to do something if you care about people in your community. If an individual has the likelihood of being exposed to the elements in middle of winter, with no other alternative, you have to put them somewhere.

" Because we have an affordable housing crisis in this country, there's a sad game of musical chairs that exists: limited slots, lots of demand. And, unfortunately, those with the greatest

Over two million persons experience homelessness every year in this country. They are very visible public persons. One third of our homeless population has a serious mental illness. Crimes of survival such as urinating in public, or panhandling—when a person has no resources—are poorly tolerated by many communities. As a result, arrests go up.

During the year preceding arrest, 30% of mentally ill inmates in jails and 20% in state and Federal prisons reports periods of homelessness. When you come out of those settings, you are behind in your finances: jails don't help you maintain your rent; landlords aren't very sympathetic when you spend 30 days in "the slammer." Family and friends may not want you when you come out. When you leave the prison setting, you have no place to go, and often end up in the tragic cycle we're all too familiar with—arrest, release, and re-arrest.

2. Persons with mental illness serve longer periods of incarceration than other inmates for the same crime.

According to a BJS survey, inmates with mental illness served an average of 15 months longer for the same sentences. Why is this? "People with mental illness who don't think clearly don't follow rules." They act oddly and are picked on; they get into fights more regularly. This means they spend more time in administrative segregation and they max out their sentences more frequently. They spend longer times in incarcerated settings for the same sentences.

3. Incarcerated environments are pathogenic in nature.

We must appreciate the pathogenic nature of incarcerated environments. They are not designed to be comfortable—this is not their purpose, goal, or mission. But when people who do not have mental illness, but are vulnerable to expressing mental illness, are put into stressful circumstances, symptoms appear. If you put folks in environments that are hypercritical, overstimulated, and tense, their symptoms get worse. Mentally ill offenders are more likely to be victimized and more likely to have periods of administrative segregation. These punitive events can result in prolonged periods of social and environmental isolation, which can lead to psychiatric disturbances. We have this phenomenon of stressing people. If you're vulnerable with a predisposition for mental illness, you are more likely to express it in a stressful environment.

Sometimes segregation occurs as a result of psychiatric symptoms. Dr. Osher stressed that treatment, not punishment, is the best answer in a situation like this. He urged practitioners to improve their abilities in differentiating the difference between behavioral problems and symptoms of mental illness.

4. There is a higher recidivism rate among inmates with mental illness than among those without mental illness.

Inmates with mental illness report more prior sentences. Discharge planning is woefully inadequate; inmates are released with too few skills, inadequate resources, and no connection to community supporters. They have very little social and family support, so they come back. The more you send in, the more come out. And when you send them out without support or adequate discharge planning, they aren't going to make it out there.

5. Folks in our society don't get good mental health care.

Health supports are all quite complicated, particularly for those with serious mental illness who need a variety of treatments that are found in different agency settings and different geographic locations. Effective case managers are hard to find. There is a lack of integration between substance abuse and mental health providers and an overall problem with integration of care. Mental health law reform has placed significant restrictions on involuntary commitment which, though appropriate, has made it more difficult to access health and treatment options. The law states that a person must be a clear and present danger, which makes access to mental health services more difficult and access to corrections more likely.

With health financing reform, managed care, and managed cost, you've got to be real sick to get into a hospital these days. The acuity level has risen so high over the past years that folks who previously would have been hospitalized are not. Managed care, managed costs, co-pays, and deductibles all provide disincentives for seeking mental health treatment in this country. Cost is the most prevalent deterrent to seeking care. But even if treatment is there, it is often not sought. The Surgeon General's Report on Mental Health published last year stated that two-thirds of those with diagnosable mental illness in this country receive no treatment. This figure is related to stigma, the stigma that allows the public—all of us—to accept less than parity for mental health treatment.

Another problem is a human resource shortage. In rural areas, mental health treatment is often not available. Most of these areas are not equipped to deal with certain cultural differences and cannot meet the needs of ethnic and racial minorities.

Science, however, should be proud of the advances made in the past decades. We've made remarkable strides in understanding how to treat mental disorders; we no longer prescribe older anti-psychotics that turn consumers into "walking zombies." We have newer medicines, new anti-psychotics with less side effects. We call these atypical anti-psychotics because they don't cause so much nerve damage like the older ones did. We have a host of selective seratonin reuptake inhibitors like Prozac that are really quite well-tolerated. The science of mental health treatment is as robust as that of somatic care. One of the most exciting things that came out of participating in the Mental Health Task Force was that mental health practitioners were able to say, "Our successful outcome rates for treating depression are just as good as your effective outcome rates for treating coronary artery disease."

" If as a group, they do more drugs, commit more crimes, spend more time on the streets, and we arrest them more often and we stress them when they're in contact with the justice system and we keep them longer in our institutional settings, and we discharge them without adequate planning and they go into communities and don't get good treatment that they need, and we re-arrest them at higher

When you look inside our fences or, more importantly, within our community system of care, people with mental illness are not getting what works. There is a huge gap between science and practice—what we know and what people get is two different things.

Mental Health 101according to Dr. Fred Osher—let's define who we're talking about when we speak about the mentally ill

Mental illness refers to all diagnosable mental disorders that are an abnormality in thinking, behavior, or mood. The diagnosis has to do with the severity of symptoms, the duration of the disorder, and the degree to which they interfere with functioning.

People think psychiatrists use voodoo to diagnose; we act
ually have a very rational way to screen, assess, and dia
gnose mental disorders. We look for symptoms of par
ticular mental illnesses; certain symptoms are seen only wit
h certain diagnoses. However, no symptoms alone equ
al a concrete diagnosis of mental illness. When the mo
st serious symptoms (such as psychosis) occur, it is very likely that the person has a diagnosable mental disorder.

" Not everyone in prison has a mental illness."

The four major symptom groups of mental illness

Anxiety includes feelings of fear and dread, lightheadedness, trembling, and shortness of breath. Some anxiety is normal and adaptive, which leads a person to evade or confront a situation, but excessive anxiety can disable an individual. Some anxiety disorders include phobias, panic attacks, and post-traumatic stress disorder.

Psychosis is a disturbance in perception and thought and is most commonly associated with schizophrenia. Psychosis can be present in severe mood disorders as well. It is a disorganized, disturbed way of seeing the world. Psychosis includes hallucinations, which are seeing, hearing, smelling, feeling, or tasting things that are not there. Even without stimuli, the person feels that something is going on around him or her. Psychosis also includes delusions, which are false beliefs despite evidence to the contrary. You cannot talk a person out of a delusion. As a psychotic symptom, a delusion must occur in the absence of a real threat. An example of a delusion is a delusion of grandeur, where a person believes he has special powers.

Symptoms of psychosis seem to have common mechanisms in our central nervous system; they are common irregularities that respond to common medications. Mental health practitioners use anti-psychotic medications to treat these symptoms.

Disturbance of mood includes sustained feelings of sadness or elevation of mood associated with disturbances in sleep, appetite, levels of happiness and depression, feelings of helplessness, and suicide thinking. (Research has shown that suicide rates in the prison population greatly exceed those of the general population.) Disturbances of mood also include elevations in mood such as mania exhibited by such symptoms as pressured speech. Mood symptoms also share a common neurological mechanism. Solid science supports very specific interventions.

Disturbance of cognition is exhibited by the decrease in ability to organize, process, and recall information. Progressive deterioration is dementia. It is very common to see disturbances of cognition co-occurring with disturbances of mood.

Diagnosing mental illness

A diagnosis is generally drawn from a patient's self-report and the clinician's observations. Clues are grouped together in recognizable patterns called syndromes, which are all listed in the DSM-IV.

Examples of mental disorders that are related to a medical condition include:

- Substance related disorders (addictions)
- Schizophrenia
- Mood disorders
- Anxiety disorders
- Eating disorders
- Impulse control disorders
- Adjustment disorders
- Personality disorder

Serious mental illness is defined by three characteristics:

1. **Diagnosis**
2. **Duration (lasting over a year)**
3. **Disability (significant interference**

It is important to distinguish between mental health disorders and mental health issues or problems. All of us experience mental health issues or problems that may not rise to the order of a syndrome. We also have to understand the difference between personality traits and personality disorders. We all have personalities that can be adaptive or maladaptive.

As clinicians, we often set one personality disorder aside in the criminal justice system because a part of it is actually defined by criminal acts—anti-social disorder.

There is a distinction between having a mental illness and having a serious mental illness and for some smaller percentage having a severe mental illness.

Screening and assessing for mental illness in prisons

The challenge that lies before us is how do we screen and assess within the corrections setting? There must be screening at every point in the continuum. A standardized measure for assessment designed to test for serious mental illness in prisons does not exist. Corrections currently uses a combination of screening tools. The Center for Behavioral Health, Justice and Public Policy has just received a grant to begin to work with other organizations to design a standardized assessment tool. Effective assessment planning must include the following:

- Mechanism for continual re-assessment
- Screening mechanism
- Ability to use inmate records
- Adequate time to observe the consumer
- Ability to get information from criminal justice to health service providers
- Mechanism for repeat screening (Helen developed bipolar disorder years into incarceration.)

- Ability to measure non-mental illness reasons for someone's bizarre mood, behavior, or thinking (We must be able to rule out medical conditions.)

The ideal is to have a sophisticated plan that allows you to narrow down the disorders you believe require intervention. Dr. Osher urged practitioners not to forget their staff, too. Staff members are not immune to mental health disorders—they are underpaid, overworked, and stressed, which can have a significant impact on their ability to perform their jobs.

What mental illness isn't—Dr. Osher outlines who we're not talking about when we speak of the mentally ill

We are not talking about persons with addictions

While co-occurring disorders are quite prevalent, and addictions are included in the DSM-IV, addictions on their own are typically excluded in strategic planning initiatives when focusing on people without addictive disorders. The reason they are separated is the recognition of the existence of separate biological causes and treatment interventions for mental illness and addictive disorders. There are separate financing mechanisms that are in place for addressing these two populations. This distinction doesn't necessarily serve our citizens well, because they often come to us with both disorders together.

It is important to recognize that substance abuse can mimic any psychiatric disorder. It has to be ruled out as the sole contribution to disturbance in mood, behavior, or thinking. Persons with substance-induced psychiatric conditions are not who we are talking about when we talk about someone with a serious mental illness. Dr. Osher saw an individual, a young Caucasian man, who had been into a run of smoking crack cocaine and because of his substance abuse, became quite paranoid. He believed people were trying "to take him out" and, when walking past a Safeway in Baltimore city, thought he saw some people inside coming after him. So he picked up a shopping cart and threw it through the window. He was arrested by the police and brought in for a urine sample. He tested positive for cocaine.

He is not the person we're talking about. He had paranoia as a symptom, but the intervention for him is abstinence.

We are not talking about persons with developmental disabilities

We are not talking about the inmates who suffer mental retardation or the ten percent of inmates who have IQs that are below 60. However, those with developmental disabilities also develop co-occurring mental disorders. Those people *are* our focus.

We have to do a little bit of narrowing if we're going to get our arms around the population.

Dr. Osher's short history of mental health treatment in the United States

Dr. Osher mentioned that correctional mental health is often a reflection of larger societal values about the care and treatment of people with mental illness in our communities.

During Colonial times, it was common to lock up those with mental illness. This practice continued on to the early 1800s, and was the basis for outrage that fueled the reform of Dorothea Dix and Horace Mann, who sold the notion that mental illness could be treated by moving people to asylums where they could receive morally-based treatment. The years 1800 to 1850 were the period of "moral treatment." Nearly every state developed an asylum designed to restore mental health. However, the promise of restorative treatment was not fulfilled. People did not return to baseline functions.

In the late 1800s and early 1900s, the mental hygiene movement developed as the asylums began to deteriorate. State care acts were passed that transferred responsibility for care from asylums to the states. These acts are primarily responsible for the centrality of state care today—they brought new concepts of public health, new scientific advances, and a progressivism that led to the development of smaller, state psychopathic hospitals. Outpatient, early intervention was advocated, but available treatments available during the era of mental hygiene reform were neither sophisticated nor scientifically targeted. Treatment was not effective; hospitals got backed up and jammed and filled with long term stay individuals.

The 1950s, 1960s, and 1970s brought with them the community mental health movement. Along with this movement came the emergence of new drugs such as Thorazine and Haldol, which were incredible advances. The community mental health centers developed the idea of treating in the least restrictive settings, which led to the policy of deinstitutionalization. However, in state mental health hospitals, these persons had been provided with a place to live, meaningful rehabilitative activities, and clothes to wear. When they were released from hospitals, they were supposed to receive community-based services that were expected to mirror and exceed those they had received in the hospitals. These services often did not exist. As a result, homelessness emerged as a National phenomenon; the population started to change from skid row, Bowery types to younger persons with mental illness.

In the late 1970s to the present, reformers advocated for community support systems and an expanded vision of comprehensive care, which included housing and social income supports. The concept of recovery was promulgated. Today we understand that we were wrong to think there were illnesses that held no possibility of a positive outcome. For most of our consumers in this country, the capacity to return to a healthy life exists.

The concept of "in vivo" support was introduced. Practitioners decided to go to where the consumer was; if they were having a problem in housing, practitioners went to the person's house. If they were having trouble with employment, practitioners would support the person on the job. Newer medications were introduced and advocacy voices grew in size and influence. National Alliance for the Mentally Ill (NAMI) provided an effective voice for loved ones with mental illness; the consumer voice gained power. The consumer voice was beginning to be recognized not only as politically correct, but as essential to designing effective, realistic responses to mental illness. This is a very difficult issue for corrections, where the consumer is a

convicted criminal. However, the consumer voice is an important perspective and can be an exciting, informed voice to add to solution development.

There is still a big gap between what we know and what we do. Our country faces the ironic return to quasi-institutionalism. We have many people with serious mental illness in jails and prisons as a consequence of a mental health system starved by public apathy. It isn't always a resource problem, but often it is.

Another reform, called Evidence Based Practice, is currently gaining momentum. Reformers are saying—if you have a dime to spend, you might as well spend it on things that we know work. Let's spend money on what has been proven, not on experiments. A large part of the Evidence Based Practice movement is its emphasis on outcomes. What is it you are trying to achieve, what does a particular consumer need?

This is where our mental health system is now—we have a long way to go.

Outline of the continuum of contact—programs that show promise

There are many opportunities to interact with inmates with mental illness along the criminal justice continuum, from arrest to re-entry. Persons with mental illness present unique challenges and opportunities at every point of contact. Awareness and training and available resources all play vital roles in determining public safety and clinical outcomes. The country's creative minds have been struggling to create more effective responses, and there are some bright lights we can look at.

The police are the first on the scene. Their interaction involves personal risk; they may or may not be connected to supportive mental health institutions in the community, and they must think and act quickly. Innovative solutions that require an eagerness to learn and a collaborative spirit have been enacted successfully around the country

The crisis intervention team program in Memphis, which has established a partnership with families to develop an educational program, has resulted in a reduction in arrests and in harm to the person with mental illness and to the police officer.

The courts—there is a growing acceptance of the concept of therapeutic jurisprudence; it is recognized as a legitimate role for the court and the belief that we can make a difference from the bench is gaining momentum. Innovative solutions have sprung from an acceptance and willingness to handle competent persons with mental illness differently. People are seeing the ability of the court to motivate change. We now have a growing mental health court movement and authorized language from Congress that will promote more growth in the future.

The jails—it is understood that jails need to segregate arrestees and convicted criminals from society—that's the mission. But we spoke earlier of the social mission that is sometimes thrust upon jails as they serve as housing of last resort. Jails inherit the failures of our public health systems, not only mental but physical health as well.

Who is passing through jail facilities?

- 16% of our country's AIDs cases
- 30% of HIV cases
- 30% of persons with Hepatitis C
- 38% of people with tuberculosis

We need to explore pre and post-booking jail diversion. We need to link inmates to necessary services within community environments.

The prisons are at the core of our discussion. They are overcrowded, under-resourced, mandated for segregation and rehabilitation; they were given a big expansion in physical plant dollars without the operational funding, so they are being asked to do more with less. This is all part of the correctional environment. However, within this environment, innovative solutions still do occur. In New York state, an Inmate Observation Aid Program has been developed and has trained 13,000 inmates to spot depression and at-risk suicide inmates. What an important development: to train inmates to screen for the most serious and potentially negative outcomes in the prison setting. The Department of Corrections in Oklahoma amended their formulary to make prescription of any and all psychotropic medications available. We need to make these new medical developments available to people even if they're behind the fence.

Re-entry—There are as many persons with mental illness coming out as going in. This mimics the deinstitutionalization dilemma that we faced in the 1980s. Inside, the people have housing, food, shelter, and clothing. Outside, they don't. There exists a tension about how to provide adequate wraparound care. Unrealistic caseloads make it impossible for parole officers to handle consumer needs. There are, however, innovative solutions that begin with the recognition of the need for specialized service. In California, they have developed a Community-Based Conditional Release program for offenders. Mentally ill offenders are released with supervision and with ongoing mental health care. Early evaluative data show that people who didn't participate in the program are four times more likely to re-offend than those who did participate in the program.

Conclusions

1. ***We need to continue to build a science base.*** **We have Evidence Based Practice interventions but we haven't extended them to a corrections-based setting yet. We need to continue to generate that knowledge.**

2. ***We need to appreciate larger societal issues.*** **We must link awareness—what's going on outside affects what's going on inside. The war on drugs is not affecting all people equally; health care is a right (it should be)—not a privilege. You have a constitutional right to health care in prisons—-why isn't there a constitutional right when you're not in prison? Homelessness is an affordable housing problem; we need to say that—there are not enough places for people to sleep. Finally, if we had better mental health in communities, we might not have so many persons with mental illness in our jails and prisons.**

3. ***We need to overcome stigma and discrimination both broadly in our public, but specifically in our corrections staff and mental health staff.*** **We must address the myths that exist and come to solutions that allow us to provide good care.**

Statistical Research Presentation—*Allen Beck*

Presente

Allen Bec
Chief
Correction
Bureau of

Dr. Beck talked about two Bureau of Justice (BJS) reports. The first was disseminated two years ago and was called "Mental Health and Treatment of Inmates and Probationers." This report was based on a survey taken in 1997 and surveys taken in 1995 and 1996. The second report is the more recent, "Mental Health Treatment in State Prisons 2000." This report was based on a census that was taken last year, which included a complete enumeration of state and Federal prisons Nationwide.

An estimated in state prisc as mentally i

- **16.2% of state survey reporte emotional con admitted to a**
- **Mid-year estim change in per**
- **No data on the or level of seri**

The world of corrections has been changing dramatically over the past 20 years. The rate of incarceration has quadrupled since 1980. There are now 1.2 million state inmates and 150,000 Federal inmates. There has been a 75 percent increase in state inmates and a doubling of Federal inmates since 1990.

Equally dramatic is the way in which the population has begun to stabilize, both in size and in composition. This equilibrium provides an opportunity to examine treatment needs, both physical and mental. Rather than being ground down by housing and incarcerating ever more prisoners; rather than being overwhelmed by finding space when the system is already overcrowded, the slowing of the population allows professionals to meet their responsibilities in assisting 1.2 million state prisoners to address their problems.

Based on the inmate survey taken in 1997, about 191,000 state prisoners may be identified as mentally ill. Dr. Beck said that the 191,000 is calculated based on current population numbers, if we assume that the 16 percent hasn't changed since 1997.

Among illness i among than am minoriti

Male
Female

White
Black

Obviously, there are limits to what amount of detail statisticians can gather through inmate surveys. BJS is working to secure better diagnoses using MAYSI and the DSM-IV. These tools will be used this fall when BJS conducts a survey of local jails.

A survey can provide a picture of the characteristics of those with mental illness. Besides the characteristics listed here, mental illness is also more common among middle-aged inmates.

Mentally ill inmates are more likely than other inmates to have been homeless, unemployed, on welfare, or abused in the past.

	Mentally ill inmates	Other inmates
Homeless in year before arrest	20%	8%
Unemployed in month before arrest	39%	30%
Receiving welfare in month before arrest	15%	8%
Lived in foster home/ institution before arrest	26%	12%
Physically/sexually abused in past	37%	15%

Mentally ill inmates are more likely to be sentenced for a violent crime and have longer records than other inmates.

	Mentally ill inmates	Other inmates
Current violent offense	53%	46%
Three or more prior sentences	52%	42%
Two or more fights since admission	24%	15%
Any charge since admission	62%	52%

Those with mental illness have substantial involvement with the criminal justice system. One in four have six or more prior arrests (not shown).

Once incarcerated, they bring with them considerable levels of behavioral problems that continue. This behavior threatens safe management. Those with mental illness have a much higher rate of involvement in fights and in rulebreaking once inside the system.

Mentally ill inmates have high rates of substance abuse and dependence.

	Mentally ill inmates	Other inmates
Alcohol dependence	84%	22%
Drug use		
th before offense	59%	56%
At time of offense	37%	32%
Alcohol/drug use		
At time of offense	59%	51%

Inmates with mental illness have significant levels of co-occurrence and testify to negative life experiences that are the result of drinking.

- 1 in 3 is characterized as alcohol dependent.
- 1 in 5 lost a job because of drinking.
- 1 in 4 had trouble at school or a job because of drinking.
- 1 in 3 reported having been arrested and held at the police station for drinking.
- 1 in 2 had physical fights before being incarcerated for drinking.
- 1 in 2 were characterized as binge drinkers, meaning they drink three six-packs in one day.

New data from the 2000 census of state and Federal adult correctional facilities

- **Mental health treatment items included for the first time**
- **Previously conducted in 1974, 1979, 1984, 1990, and 1995**
- **A complete enumeration of all public and private adult facilities under state of Federal jurisdiction**
- **Included 84 Federal facilities; 1,295 state facilities; 22 under state and local; three DC facilities; and 264 privates**
- **463 state facilities were community-based; 1,121 were confinement facilities**

The inmate survey provided a basic profile of the offender with mental illness. It did not, however, provide information about treatment or about treatment policy. BJS tracked this information by conducting a census, which included mental health treatment items for the first time. The census was a complete enumeration of all public and private persons.

State prison systems typically screen inmates for mental disorders at reception/diagnostic centers.

- **At mid-year 2000, 161 of the 1,558 state public and private facilities were reception/diagnostic centers.**
- **Every state had at least one facility serving this function.**
- **Nearly all facilities (153) either**

Most correctional facilities screen inmates for mental health problems and provide treatment.

Reception diagnostic centers look for the best placement in a correctional facility or a forensic facility in a state mental health hospital. Each state had at least one facility that functioned in this capacity.

alth policy

92%
intake 70%
sychiatric assessments
65%
-hour mental health care

One in ten inmates were receiving psychotropic medications; one in eight was in mental health therapy or counseling.

Percent of inmates receiving:

	Therapy/counseling	Psychotropic medication
All	13%	10%
Public	13%	10%
Private	10%	7%
Confinement	13%	10%
Community-based	9%	5%
Males only	12%	9%
Females only	27%	22%

Not all therapy and counseling programs are the same—some states are more inclusive, some are more restrictive in how they characterize therapy or counseling.

The statistics are based on policies that are in place; they may not reflect the treatment actually being provided.

The numbers associated with public and private prisons may reflect the types of people who get into each facility (not necessarily the facility's willingness to give out medication). However, it may also reflect a willingness or unwillingness to disperse medication.

Persons placed in community-based facilities may have been chosen because of their high level of functioning and may have less need for services. This is something to consider when looking at these numbers. Those already diagnosed with serious mental illness don't usually end up in community-based treatment facilities.

79% of mentally ill inmates are in therapy; 60% are receiving psychotropic medications.

	Estimated #	Percent of mentally ill
In 24-hour mental health care	18,900	10%
In therapy/ counseling	150,900	79%
Psychotropic medications	114,400	60%

Here, the statistics are translated relative to the numbers in need of treatment. Again, the study is not addressing the quality or effectiveness of the program.

Most treatment is provided in general confinement facilities.

- **70% of inmates were receiving therapy and 65% of those were receiving medications in general confinement.**
- **80% of those in 24-hour mental health care were in a specialized facility.**

155 state facilities in 47 states specialized in psychiatric confinement.

	Total	Primary	Secondary
	155	12	143
Number of inmates	217,420	8,124	209,296
Percent of inmates			
In 24-hour care	7%	48%	5%
Therapy/counseling	19%	47%	18%
Psychotropic meds	17%	45%	16%
Percent of capacity occupied	100%	88%	100%

Twelve facilities in 155 states had, as their sole function, psychiatric confinement.

Secondary facilities have a general population as well, but have special treatment opportunities for persons with mental illness.

Some of the categories overlap—for example, some inmates may be receiving both counseling and psychotropic medication.

Overall, the facilities are operating at nearly full capacity. The primary facilities are generally smaller than the secondary facilities.

In four states, at least 25% of inmates were in mental health therapy/counseling.

Percent of inmates in therapy/counseling

Five highest		*Five lowest*	
Maine	**33%**	**Hawaii**	**3%**
Louisiana	**27%**	**Tennessee**	**7%**
Wyoming	**37%**	**Alabama**	**8%**
Nebraska	**28%**	**New York**	**10%**
Indiana	**24%**	**Michigan**	**10%**

In five states, nearly 20% of inmates were receiving psychotropic medications.

Percent of inmates receiving medications

Five highest		*Five lowest*	
Maine	**24%**	**Missouri**	**4%**
Montana	**21%**	**Arkansas**	**4%**
Hawaii	**20%**	**Michigan**	**5%**
Nebraska	**20%**	**Alabama**	**5%**
Oregon	**20%**	**Illinois**	**7%**

This information shows the variation by state. The aggregate numbers for states give a sense of the volume of people in treatment.

Again, therapy and counseling may mean different things in different states.

Statisticians can have more confidence in psychotropic medication numbers—there is no variation in definition here.

Census data do not measure the treatment gap.

- **States may differ in how they report therapy and counseling from a mental health professional.**
- **Quality and effectiveness of treatment programs vary, but cannot be measured at facility level.**
- **Need for treatment cannot be collected in a facility census.**

New mental health screening measures to be introduced in BJS surveys.

- **Based on the 1997 survey experience, BJS is adding items from the Massachusetts Youth Screening Instrument (MAYSI) and DSM-IV.**
- **Items included will measure conditions before admission, such as:**
  - **Anger/irritability**
  - **Aggressive behavior**
  - **Depression/anxiety**
  - **Delusional/paranoid tendencies**

BJS will be introducing new measures in upcoming surveys to get a better picture of the dimensions and severity of mental illness in facilities across the Nation. They will be including diagnoses from mental health professionals, using diagnostic categories from the Massachusetts Youth Screening Instrument (MAYSI) for juveniles and the DSM-IV for general diagnoses.

Statistical Research Presentation—*Bonita Veysey, Lucille Schacht*

Presenters

Bonita Veysey
Assistant Professor
School of Criminal Justice,
Rutgers University

Lucille Schacht
Statistical Analyst
NASMHPD Research Institute, Inc.

Dr. Veysey and **Ms. Schacht** introduced their recent statistical study of medications entitled, "Psychiatric Practices in U.S. Prisons and Jails."

The study was sponsored by Pfizer Pharmaceuticals, and it was spurred by data that showed that the cost for psychiatric medications in corrections is skyrocketing; costs were second only to HIV medicines.

The study was small, undertaken in pilot format and targeted at larger facilities with over 1000 inmates, because the researchers thought that these facilities were most likely to have a wide array of services available. Data was gathered through a mail survey, which was mailed twice. At the time of the conference, the researchers had received responses from 67 % of the prisons surveyed and 27 % of the jails. The jails that did not respond made it clear that the time and staff needed to complete the survey was more than they could afford at the time.

Prison facilities surveyed:

- **Average current population: 2,117**
- **Average admission in one year: 2,630**

On average, 13% of current inmates are receiving mental health services (maximum capacity 36 %).

On average, 25 % of inmates in the past year received mental health services (maximum

Jail facilities surveyed:

- **Average current population: 1,540**
- **Average admission in one year: 23,638**

On average, 14% of current inmates are receiving mental health services (maximum capacity 28 %).

On average, 17% of inmates in the past year received mental health services (maximum

There were extreme differences in the way that jails and prisons handled medications; jails had to deal with a much higher rate of turnover and much shorter stays with the same prevalence of need.

Because of this, jails provided a lot of screening, but much less therapy than prisons.

Who operates Mental Health Services?

Staff employed by	*Jails*	*Prisons*
Corrections Department	**69%**	**35%**
State Mental Health Authority	**6%**	**5%**
County or regional MHA	**--**	**20%**
Local MHA	**--**	**30%**
Behavioral health contract	**44%**	**55%**

Some facilities' services are operated by more than one group.

The information gathered about the operation of mental health services should help those who are building service plans. Over 40 % of the prisons surveyed contracted their mental health services out, (over 50 % of jails).

Jails and prisons both reported large numbers of inmates (approximately 70% of the current treatment group) with co-occurring mental health and substance use disorders. This statistic should also be taken into consideration when facilities are building service plans.

Crisis intervention

Use emergency medication to prevent suicidal ideation
Prisons 69% Jails 84%

Use chemical restraint frequently to prevent suicide in high-risk situations
Prisons 5% Jails 21%

Use chemical restraint frequently for clinical reason

The numbers reflecting the use of medication for crisis intervention also reflect the differing needs of prisons and jails.

Continuity of Care: Prisons

Access to clinical information from outside

- **93% request information from mental health agency**

When offender is admitted on psychotropic medications

- **27% continue medication, 46% based on new evaluation, 27% both continue and based on new evaluation**

Upon release

- **One-third each provide 30-day and 14-day medication supply**
- **One-fourth provide a prescription**

Survey results show that drugs do follow inmates into the prison. When the inmate leaves the prison, 25% are provided with a prescription and 33% are provided with a medication supply along with their prescription.

Survey results also showed that 25% of the population has schizophrenia. An atypical formulary was used a little less frequently than traditional medication. Anti-psychotics and mood stabilizers were the most commonly-used types of medication.

Factors determining medication use

1. **FDA-approved indicators**
2. **Personal clinical experience**
3. **Accreditation requirements or professional standards**
4. **Research-demonstrated efficacy**
5. **Training received through continuing education or professional meetings**

Other

Financing or cost concerns (especially among those facilities not using new

The researchers asked prisons and jails to list the top determining factors they used to choose medication. The top five are listed here. Cost concerns were more prevalent among those who were not using the new generation of medications, which tend to be more expensive. Most jails and prisons tended to use a mixture of medications.

Next steps

- **Case studies of both prison and jail mental health services: planning delivery, and evaluation**
- **Characteristics of population in mental health, corrections, and juvenile justice**
- **Similarities and patterns between correctional and mental health institutions**
- **Probable estimated overlap between**

The researchers concluded by telling conference participants of their future plans for delving deeper into the patterns of medicinal use. They are going to use individual case studies to look more closely at the process.

They are also interested in examining the pattern of back and forth movement between the mental health and corrections systems.

Panel Discussion: The Challenge

Moderator

Richard Stalder
Secretary
Department of Corrections, LA

Panelists

Walter Kautzky
Director
Department of Corrections, IA

Richard Ferrie
Lieutenant
Department of Corrections, MA

Kathleen Dennehy
Deputy Commissioner
Department of Corrections, MA

Risdon Slate
Professor of Criminology

This panel was deliberately composed up of those involved with corrections—a number of these panelists are the people within the walls who deal daily with hands-on correctional issues. Key issues raised by the panelists follow.

Walter Kautzky on the resource problems that stem from corrections having to deal with mental health issues.

Are criminal justice facilities equipped to deal with mental health issues? Mr. Kautzky suggested that practitioners need to craft the challenge so that they are better prepared. The more one concentrates solely on controlling offenders, the less likely they are to get treatment. He mentioned the Hoover Mental Health report and the problem of trans-system challenges. He told the audience of the emergence of mental health and said that it is no longer background noise in corrections.

Mr. Kautzky said that the density of inmates with mental illness in the prison population has increased substantially and that this growth (due in part to deinstitutionalization) poses an enormous challenge for corrections systems. The difficult task facing corrections officials is to develop strategies and form partnerships that allow them to identify and use resources previously dedicated to state mental hospitals.

Mr. Kautzky asked the other panelists whether disciplinary policies actually filter out offenders with mental illness. Corrections exists in a culture of punishment. Is this culture capable of understanding and filtering out the offenders who tend to require more control? Are community services out there?

Key themes:

- **Prison management and practices**
- **Prison population with an emphasis on inmate safety**
- **Services provided in prison**

Financial resources are always a challenge—what is the best way to balance resources between mental health and corrections? The Council of State Government's report was helpful in describing strategies for collaboration; but nothing can be done without the resources.

Mr. Kautzky suggested that there are not adequate standards currently set up to guide the practices for dealing with mental illness in corrections. He urged participants to attempt to begin to create standards during their conference discussions.

Risdon Slate on a personal experience in the criminal justice system.

Professor Slate told his personal story of involvement in the criminal justice system. He suffered from depression and experienced a full-blown manic episode, after which he was hospitalized for two weeks. He was asked to resign his job as a parole officer and decided to go off his medication. He then suffered another full-blown manic episode and was arrested. He offered a personal perspective about the damage and injustice that can result when untrained staff deal with a psychotic individual.

According to Professor Slate, the criminal justice system has become a dumping ground for persons with mental illness. He asked all to consider where these people belong. The current process, starting at the booking stage, determines, often inadequately, whether these people belong in prison or with a mental health services provider. Professor Slate posed this question: "Prisons are about control—even if you can stabilize someone with mental illness—can you get them straightened out in a system that is about control?"

Rick Ferrie on using common sense and on providing mental health training for corrections officers. Officer Ferrie spoke from the perspective of a corrections officer and stressed that officers must understand the difference between behavior problems and symptoms of mental illness. The key is to provide ongoing training so that officers can read clues about changes in behavior that might point to mental illness. Officers must:

- Be able to use resources and recourses.
- Know the population.
- Gain experience—not everything works on every person.
- Get mental health professionals involved.
- Use commons sense and not take things personally.

Officer Ferrie stated that the officer doesn't necessarily need to know details about an offender's illness; he or she just needs to take the time to ask questions.

Kathleen Denehy on the problems of information-sharing and the lack of innovative solutions that address non-compliance and decompensation. Ms. Denehy stated that she thought that the point of admission is the most critical point of the continuum and the point for which we have the least amount of information available.

There is a lack of integration of services, which can only be addressed when the system begins to draw a complete picture of the offender. There is a widespread problem of inmates being shuffled back and forth between corrections and mental health service providers. As it currently stands, the system is wasting resources, and inmates with mental illness are deteriorating. These individuals' deterioration spawns a downturn in the entire facility's environment. Assessment tools need to be examined and modified. Persons with mental illness in prison can cause extreme management challenges. Some of these issues include legal considerations, confidentiality problems, training requirements, and forced treatment questions. One of the most overwhelming blockages to collaboration is the inability to share information. It is difficult, if not impossible, to access records about an inmate's previous mental health history; this challenge to information-sharing, both logistical and legal, is also an intra-agency problem. Some barriers to confidentiality will be eased only with statutory change.

The challenge is also to overcome the traditional philosophical barrier that exists between the behavioral sciences and the criminal justice system. It is only through this effort that practitioners will be able to develop meaningful treatment plans for individuals within the prison population who have mental illness. A major question to address is: how do you treat non-compliance in a prison setting? People don't often think that there may be reasons why the inmate is refusing the medication and that these issues can be addressed in innovative ways. Prisons need to examine the issue and set up mechanisms to deal with non-compliance, including legal options. There is no need to reach a crisis point; the threshold of intervention can and should be lowered. Ms. Denehy recommended one such solution might be to have clinicians tap into the inmate's personal relationships and bring in outside people such as a chaplain to deal with the non-compliant inmate on a personal, interactive therapeutic level.

Appropriate assessment instruments also need to be developed. Practitioners need time, privacy, and money to screen and assess; the first impression needs to be documented, if we want to develop a meaningful treatment plan.

The re-entry problem raises a lot of issues because, in many states, the services simply don't exist. Ms. Denehy urged conference participants to hone their political will and use it to gain the necessary resources for integrated re-entry services.

Lunch Presentation—*Carla Jacobs*

Speaker

Carla Jacobs
Chair
Criminal Justice Advisory Committee

The criminalization of people with mental illness

Many current involuntary treatment laws were drafted 30 years ago when little was known about the biological basis of mental illness and its inherent cognitive impairments. Most commitment codes in the United States enact treatment on an involuntary basis for people who are considered to show behaviors resulting from their illness that are dangerous to self (including gravely disabled) or others. They do not allow treatment for people who have substantially deteriorated in their cognitive functioning because of mental illness or those who do not have the capacity to be aware of a need for treatment. As a result, these people do not receive the early and continual medical intervention and support they need to recover. The social tragedies that result from untreated brain diseases are also not prevented. Ms. Jacobs used California to illustrate how commitment codes affect criminalization.

The consequences of lack of treatment for people with mental illness

The number of mentally ill individuals entering California's jails nearly doubled in the first year of the Lanterman Petris Short Act, considered the "granddaddy" of most commitment codes. The sharp influx of persons with mental illness in jails who were no longer in state hospitals or under the supervised structure of its conditional discharge program was astounding. Santa Clara County's jailed mentally ill population jumped by 300 % in the four years following the closing of a nearby state hospital. By 1975, counties throughout California were experiencing a similar increase of inmates with mental illness in their jails. A study eight years after the change in commitment standards found a five-fold increase in the arrest rate of mentally ill individuals.

The criminalization of the mentally ill was not restricted to jail; inmates with mental illness in prison also rose at a startling rate. One prison psychiatrist summarized the problem this way: "We are literally drowning in patients, running around trying to put our fingers in bursting dikes, while hundreds of men continue to deteriorate pyschiatrically before our eyes into serious psychoses." The crisis stems from recent changes in mental health laws allowing more mentally sick patients to be shifted away from the Mental Health Department into the Department of Corrections. By 1972, task forces were being set up to study how to divert persons with mental illness away from county jails and into mental health treatment. Today, very few programs in California have succeeded in reducing the number of mentally ill in its jails and prisons.

The phenomenon of the mentally ill filling jails and prisons is just one part of the revolving door syndrome that began when California removed "need for treatment" as a criterion for involuntary hospitalization. The short-term stays without structured community re-integration programs made for multiple, ineffective, psychiatric hospitalizations. In the hospital, the patient stabilized on medication, but after release, stopped taking it and decompensated, becoming overtly psychotic and eventually dangerous again.

The financial impact of the criminalization of the mentally ill is devastating to the state of California. Overall, the cost to apprehend, adjudicate, and incarcerate people with mental illness in California is between $1.2 and $1.8 billion annually.

The criminal justice system is ill prepared to act as a treatment system for people with mental illness. Law enforcement officers average 4.5 hours training on mental illness, but must respond to calls involving mental health crises as frequently as they do calls of burglary. Never intending to become hospitals, California state prisons remain in constitutional violation for failing to provide mental health treatment to mentally ill inmates. Los Angeles County Jail is under investigation by the Department of Justice over its treatment of mentally ill inmates.

When a person with mental illness is arrested in California, the charges are usually fairly minor: loitering, disturbing the peace, simple assault, and other misdemeanors. Unfortunately, there are also significant numbers of crimes of violence, usually directed towards family or friends.

The key to criminal behavior resulting from mental illness invariably relates to lack of treatment and structure in the person's community living. Generally, the jailed population is an uncared for group of people who have experienced a revolving door system of psychiatric hospitalizations, homelessness, and jailings. One California study found one-third of the mentally ill inmates it studied were transients; four-fifths of them displayed overt signs of mental illness, such as delusions or hallucinations. Ninety-nine percent had previous psychiatric hospitalizations and 92% had arrest records (75% for felonies). Over 50% were charged with felonies and 39% with crimes of violence. Three-fourths met current standards for civil commitment. Of those charged with misdemeanors, more than half had been living on the streets, on the beach, in missions, or in cheap hotels, compared with less than a quarter of those charged with felonies.

Police, when confronted with a person experiencing symptoms of mental illness, generally can leave the person in the community or initiate voluntary hospitalization or arrest. When the criteria for hospitalization are too stringent, behavior too bizarre, or if the person commits a felony, arrest becomes the best solution.

New methods must be devised to provide treatment for people who refuse medication and services due to the severity of their illness. Innovative policies that provide continuous structured treatment for people with mental illness through forms of court ordered community treatment for the severely impaired individual with mental illness have been very effective in reducing both hospital readmissions and criminalization.

To be successful, such programs must be combined with intensive case management services that can provide people with mental illness the structure they need to function in the community and maintain needed medication regimes. However, intensive case management alone cannot prevent criminalization or re-hospitalization. In fact, when intensive case management services are combined with a restrictive commitment standard such as is presently available in California, there is incentive on the part of the mental health providers to allow patients who are noncompliant with treatment, who are decompensating, and are unwilling to be admitted voluntarily for psychiatric hospitalization to go to jail. In jail, they might receive treatment in secure surroundings.

Persons with mental illness need treatment commensurate with the level of their symptoms and functioning. The least restrictive environment principle does not mean that the person with mental illness should receive no treatment or insufficient treatment.

To stem the criminalization of people with mental illness, civil commitment codes must be revised to allow early intervention with continuous structure and supervision once the severely mentally ill person is released from the hospital into the community.

Ms. Jacobs urged conference participants to lead efforts to commit the system to providing treatment She asks, "Why do we live in society?" The answer is, "To help and protect each other." She asked all to recommit themselves to understanding the victim who is the person suffering from mental illness and to base all efforts on the knowledge that treatment works if you can get it and if you can get it early.

Panel Discussion: Yours, Mine, or Ours?

Moderator

Stephanie Rhoades
District Court Judge
Alaska District Court

Panelists

Joan Gillece
Assistant Director
Mental Hygiene Administration, MD

Reggie Wilkinson
Director
Department of Rehabilitation and Correction, OH

Martin Horn
Secretary of Administration, PA

Jeanine Long

Key issues raised by the panelists follow.

Key themes:

- **Who should be responsible for identifying, treating, and managing offenders with mental illness in institutions and the community?**
- **What are the barriers**

Reggie Wilkinson on the importance of establishing true collaboration with the community and of providing adequate mental health care in the prisons.

Mr. Wilkinson stated that, currently, the typical scenario in prison mental health care is based on the model where mental health professionals come in and provide mental health services.

In his state of Ohio, when the Department of Corrections was dealt a lawsuit, the leadership decided to agree with the court on certain provisions, instead of fighting against mandates. Since then, the department has worked to develop partnerships with many people, including the courts. The goal is truly to send folks back to society fully-prepared and this demands collaborative efforts—corrections cannot do everything on its own. It is important to work with all the stakeholders—including local governing authorities like the county boards and local law enforcement who can help inmates with mental illness transition from jails and prisons back to the community. Corrections employees must develop strategic plans about how to best partner with local groups that are involved with transition. It is also imperative that planners include integrated treatment options for those inmates with co-occurring disorders. Ideally, inmates' transition back to the community should be supported by a seamless continuum of collaborative support services.

Even considering the promise of conferences such as this one, there still exists a real difference between the mission of the mental health community and the mission of the corrections community. The mental health community must continue to try to fully understand the corrections mission and to give it the attention and respect it deserves.

Mr. Wilkinson urged practitioners to realize the cost of not providing good mental health services. If prisons aren't supplying psychiatrists and smart psychotropic medication programs, the financial and operational damage to the institution will eventually be devastating.

Mr. Wilkinson said that the reality is that judges are sending offenders to prison because they know they will receive treatment there. So, even if the prisons aren't the ideal place for a person with mental illness, the inmates with mental illness are there and the responsibility to care for them is also there. Because of this, it is imperative that corrections workers are sufficiently trained to be able to distinguish between those who are mentally ill and those who are not. Effective intervention options for the two populations are very different, and the choice of intervening in a correct way or in an uninformed way is the difference between good management and potential crisis. Mr. Wilkinson stated that if prisons do

good mental health, they also do good prison management. He underscored the importance of training staff to identify unusual behavior and to seek out crisis intervention.

Mr. Wilkinson stated that he believed there are three action items that would help to move the agenda of the conference forward in each state:

1. Communities need to have more conferences such as this to "propagandize" the need.
2. Practitioners and advocates need to lobby for prison use of Medicaid money to treat people when they are incarcerated.
3. Communities and prisons need to work together to make sure that options are available within the community. If not, the system is setting inmates up to recidivate.

Joan Gillece on the possibility of true collaboration and of the importance of organizing collaboration behind a strong political will. Dr. Gillece shared a personal story about going to a warden's meeting, 10 years before, and understanding that the inmates with mental illness in the corrections department were "her people" too. They needed to be as much of her focus as any other citizen in her jurisdiction with mental illness. This was a moment of great insight for her; previously she had thought of these people as divorced from her work and strictly the responsibility of corrections professionals. In her state of Maryland, they were able to secure $200,000 to pilot some innovative programs. They brought together traditional "enemies" of mental health and worked to create true collaboration. Finding resources and establishing collaboration was the result of organizing and harnessing the necessary political will.

Maryland established programs that promoted cross-training where people learned to speak one another's languages. The Department of Mental Hygiene and other state agencies worked together to provide accessibility to community-based treatment for those who were transitioning out of jails and prisons. Dr. Gillece stressed the importance of providing housing for inmates with mental illness in transition and of partnering with the Department of Housing and Urban Development (HUD).

The state of Maryland received two grants from SAMHSA in support of their innovative programs and involved everyone (especially corrections employees such as wardens) in the grant process and in all mental health-related initiatives. There has developed a real partnership between state and Federal mental health and corrections agencies in Maryland. One of the most difficult barriers to overcome is the language barrier—people from different disciplines can misunderstand one another and even alienate one another through language differences that reflect what was traditionally viewed as disparity in mission. She suggested establishing cross-training programs where different agencies can learn from one another and reach a common ground from which to effectively collaborate. It is only through this collaboration that states can establish the political will necessary to secure the resources that will allow them to provide effective treatment for inmates with mental illness as they transition back into society.

Martin Horn on including the Governor's office in the collaboration. Mr. Horn said that in most states, the issue of who is to deal with inmates with mental illness in the prisons never comes to the attention of the Governor's office. Advocates push education, roads, and funding and other initiatives.

Mental health treatment for the prison population must become part of the resolution. Practitioners and decision-makers need to decide which agency does it best. They need to think about which model works best; there are currently two organizational models used in the country today. The first, which is used in Pennsylvania, is to employ corrections employees as mental health workers in the system. The other is to bring in mental health experts to fulfill those roles in the prison. The two communities need to begin examining and documenting which model works best.

It is imperative that prisons join in collaboration with the community—the parole board needs to be included in decision-making and their role needs to be specifically defined, so that everyone is moving in

the same direction. The Governor's offices, because of their broad, state-wide view, should be involved in solving cross-agency communications problems.

The big challenge is to see how corrections directors and mental health directors can play, as a team, in a field that has an increasingly high number of offenders with mental illness in its prisons. States must address the issue of funding and determine the gatekeeper for dedicated money and resources must be used wisely. Only through this intense, sincere collaboration can we realistically face the challenge of handling transition and re-entry.

Jeanine Long on the importance of political impetus and the role of the legislators—they are not the bad guys. Ms. Long suggested that one of the things lacking was political impetus. She said that while it was hard not to do something about the problem, it is also hard *to do* something. In the world of legislation, money is always a barrier. Because of media hype and public attention, it is easier to get money for the dangerously mentally ill than those who are considered not "dangerous." The tragedy is implicit in the problem—if states had more mental health money up front, there would be fewer people with mental illness in the juvenile system and in prisons. Currently, in her state, there is no movement for funding directed at people who are mentally ill and have not committed a crime.

Ms. Long said that there are contributions legislators can make by being smart about how they run bills. Sometimes legislators introduce bills just to bring attention to the issue without expecting them to pass. This is a first step that can pave the way for future legislative action. The bottom line for a legislator is that he or she must spend taxpayers' money well. Because of this, Ms. Long commented, she always writes an evaluative piece into any piece of legislation she crafts, which allows evidence-based continuation or reform of a particular funded program.

Practitioners must include legislators in their collaborative teams if they want to secure resources. They must remember philosophically that *legislators are not the bad guys.*

Ms. Long suggested that the way to get the legislators' attention about this particular issue is to publicize what the bottom line will be—for state finances and state public safety—if this particular population is ignored. Judges are currently sending people to corrections to get treatment. It is the job of legislators, mental health practitioners, and corrections practitioners to change attitudes about serving this population by publicizing alternative measures and the philosophy of early intervention and prevention. The work to change the attitude can begin now or it can begin later. It will require collaboration and the organization of resources to create the political impetus for change.

Ms. Long mentioned "categorical funding" and stated how difficult it is to get funding that allows treatment of the whole person, instead of just parts of the person. She said that it is unrealistic for states to depend too much on Federal dollars in their planning. The Federal government will not augment long-term care because of the Institutions for Mental Disease (IMD) exclusion.

Panel Discussion: Exploring Legal Issues

Moderator

Jeffrey Shorba
Assistant Commissioner for Management Services
Department of Corrections, MN

Panelists

Glen Goord
Commissioner
Department of Correctional Services, NY

Linda Berglin
State Senator, MN

Ron Honberg
Director of Legal Affairs
National Alliance for the Mentally Ill (NAMI)

John Petrila
Chair and Professor
Department of Mental Health Law and Policy

Key themes:

- **How have laws and litigation affected the policies and procedures related to treatment and incarceration of offenders with mental illness?**
- **Perspectives presented from the viewpoint of a legislator, a corrections commissioner, an advocate for inmates who are mentally ill, and a state mental health agency's**

Key issues raised by the panelists follow.

Glen Goord on the positive role litigation sometimes plays. The logical outcome to the corrections community's current handling of mental illness in the prisons and jails is often litigation. Commissioner Goord said that officials cannot effectively run an organization through threat of a lawsuit. Instead, they need to create realistic policies that allow them to serve the population in a way that upholds legal standards, promotes operational management, and supplies the inmates with the most effective treatment possible. A priority should always be the safety and security of inmates. This priority demands that corrections provide resources and education to their staff, such as mental health training for officers so that they are able to recognize mental health issues and to intervene in a targeted, informed way.

Commissioner Goord also indicated that, "Litigation for corrections administration is not always bad—sometimes litigation brings needed resources." He cited the release-planning program in New York City for the jail system. This program, which mandates transitional type of planning, was moved forward by litigation. Decision-makers and leaders can, however, prevent litigation through up front cooperation and collaboration.

John Petrilla on how institutional changes are muddying legal boundaries. Mr. Petrilla focused on putting institutional litigation into a historical legislative context. He suggested that it is important to examine the changes that have taken place in the formal authority of mental health systems over the past years. There are many fewer free-standing mental health agencies than there were previously. State mental health agencies have experienced a decrease in spending; spending instead has gone to corrections and education. The current legal boundaries for mental health agencies are unclear.

Local issues and options affect who ends up in the criminal justice system—the presence of innovations such as drug courts and mental health courts are reducing the formal role of the state mental health agency.

Regarding institutional litigation, there is a significant difference of opinion between members of the criminal justice community and members of the mental health community about what causes certain behavior inside the institution. This raises definitional issues and confidentiality issues that could lead to litigation.

Other problems that exist for prisons and the mental health community are:

- The implementation of the Olmstead decision. (Certain types of institutionalization will be classified as illegal segregation.)
- Sexual psychopath issues.
- Outpatient treatment—inmates become competitors with others in community who also have mental health issues, but have not been incarcerated.

Ron Honberg on the Olmstead decision and involuntary outpatient commitment. Mr. Honberg recommended a book called *Out of the Shadows* to the conference participants.

He posed the following questions: Are there legal mechanisms that compel states to supply treatment? The Olmstead decision is a Supreme Court ruling of June of 1999 that provided mental health advocates with a decision that legally mandates making community-based treatment available to those eligible, unless such community placements will cause a state to "fundamentally alter" its provision of services. Mental health experts and treatment professionals are to determine a person's eligibility. In order for the ruling to apply, these advisors must recommend *unanimously* that the person will benefit from, and is also able to handle a less-restrictive treatment setting.

Mr. Honberg is not sure how much the Olmstead decision is likely to benefit people with mental illness. According to Mr. Honberg, the biggest problem, by and large, is getting short-term care; the Olmstead decision will only address people at risk of institutionalization. The Olmstead decision will probably not apply to jails and prisons except for very specific issues.

Mr. Honberg discussed outpatient commitment and the dilemma of working with people who consistently refuse treatment to their own detriment. NAMI's position says that involuntary outpatient commitment should be used only as a last resort. It advocates this position because it feels this mechanism needs to be in place if the state is going to be truly effective at curbing the incarceration of people with serious mental illnesses. He reiterated that NAMI believes in involuntary outpatient commitment *only as last resort*; the organization believes that there must be other resources available, such as accessible community services.

Mr. Honberg urged society to move towards a greater understanding and appreciation for the role of corrections in treating a great portion of our country's population of mentally ill. Corrections should have access to the newest, most effective medicine; they should receive the resources necessary to effectively treat the population within their walls. However, there should be continuous cross-training and a constant concern and vigilance about how disciplinary actions are used for people with mental illness in jails and prisons. There are still cases in existence where people are put in restraining chairs to discipline and intimidate; there should be a unanimous call to use less punitive sanctions for those in corrections settings with mental illness.

Linda Berglin about the power of legislation. Ms. Berglin observed that statistics show that over 17% of the population of mentally ill in prisons are receiving psychotropic medication. This statistic speaks about a population where persons of color are disproportionately represented. Research has shown that, generally, the stigma of mental illness is even more profound and deeply embedded in minority cultures than in other populations. Ms. Berglin suspects that this figure is low because of stigma-related underreporting.

Ms. Berglin mentioned the Redwing facility in Minnesota, known as "the last stop" for juveniles. When state leaders visited the facility, they saw juveniles with serious mental illness being housed in small, isolated rooms. This is exactly the kind of stressful environment described earlier by Dr. Osher that tends to aggravate, rather than ameliorate the symptoms of mental illness. After the visit to the facility, the state legislature proposed the building of a mental health unit. Legislation freed up money to build a facility dedicated solely to supplying mental health services to youths with serious mental illness.

General discussion for future initiatives and planning:

- **Centralization of discharge planning** is one innovation that could promote consistent collaboration and follow through. New York has tried centralizing discharge through one facility.
- **We need to hear more about the mental health courts movement.** How are people assessed to gain access to mental health courts? The mental health courts movement is very quiet about around the country. Corrections and mental health workers should concentrate on learning more about options that divert persons with mental illness from the criminal justice system.
- **Is punishment a viable option for non-compliance?** Punishment is used for non-compliance in drug courts. Can or should we use punishment for non-compliance in mental health courts?
- **Promote research about outpatient commitment's effects.** There is very little research about what effect outpatient commitment has. What is the real message? Without enhancement, without increased service, there is the false assumption that the statute to change the law for involuntary confinement will have a big effect.
- **Is treatment oversold as a reducer of recidivism?** Are we overpromising what treatment can produce?

Day two
July 19, 2001

Theme

Exploring Treatment Options and Best Practices

State of the Research—*Dr. Robert Drake*

Speaker

Robert Drake, M.D.
Professor and Director
Psychiatric Research Center
Dartmouth University

Summary of what mental health professionals know about good mental health treatment for persons with severe mental illness

Dr. Drake introduced himself by saying that he, like many mental health professionals, comes from a family with a history of severe mental illness. He has spent the past 50 years trying to find better treatment and intervention options for this population.

He told the participants up front that he is not very knowledgeable about the criminal justice system and that the goal of the mental health community has always been to keep clients out of the criminal justice system through diversion or, upon release, through interventions that prevent criminogenic behavior in the community. However, Dr. Drake said that he and his colleagues realize that many of their clients are going to intersect with the criminal justice system in this day and age.

He delivered a summary of what mental health professionals currently know about good mental health treatment for this population.

Defining the population—persons with severe mental illness

Dr. Drake spoke primarily about the 2% or 3% of the population affected with severe mental illness. Persons with severe mental illness possess the following three characteristics:

1. They have a diagnosis of one of the major psychiatric disorders, such as Bipolar disorder, Recurrent Psychotic Depression, Schizophrenia, or Schizo-affective disorder.
2. They suffer from the disease over a period of years.
3. Their functioning is greatly debilitated. The functions usually affected include problems with independent living, problems in working, and problems interacting with family and friends.

A historical perspective—from the hospitals to the community

Dr. Drake presented a historical perspective about the dramatic changes in mental health treatment over the past 50 years. Fifty years ago, hospital stays for persons with severe mental illness were based on the institutional perspective and the average length for a first admission stay was about 40 years. So, for example, a person suffering from schizophrenia in 1940 or 1950, diagnosed at 18 years old—which is the typical age for onset of that disease—would be sent to live in the hospital for 40 years. Essentially, these people lived the majority of their lives in hospitals.

Fifty years ago, mental health professionals began to move people out of hospitals. This movement was a result of many scientific advances and societal changes, including the development of new medications, changes in the political and legal system, and the growing voice of the consumer perspective. People were no longer sentenced to life in a hospital. The dramatic change in philosophy and policy is illustrated by the example Dr. Drake provided about his home state of New Hampshire. The average stay for a first episode for a person with schizophrenia in his state is now seven days instead of 40 years.

These are the findings of mental health professionals over the past 50 years about community-based mental health.

1. **When mental health professionals moved people out of the hospitals, *they looked much better*—not because of treatment but just because they were out of the hospitals and in the community. This led to the realization that much of the exacerbation of the disease of severe mental illness was a direct result of just being in an institutional setting. People's skills atrophied; they developed bizarre adaptive behaviors as a result of institutionalization.**

2. **A lot of training that was done in the hospital was ineffective because it did not transfer back into the community. This phenomenon could be related to the special learning disabilities associated with persons with severe mental illness. If practitioners wanted to teach people to cook in their apartments, they needed to do the actual teaching in those same apartments, rather than in the hospitals.**

3. **It is difficult to coordinate services in the community and integrate resources such as medical, vocational, housing, interpersonal support, and financial services. In the hospitals, people were getting all these services in a centralized all-service facility. In the community, these services were fragmented. As a result, persons with mental illness were not receiving the**

Over those 50 years, the mental health community has learned a lot about providing good mental health care in the community.

Dr. Drake broke the historical developments down into phases. He defined the first phase by its mental health goal—that of achieving ***stabilization*** in the community so the patient could stay out of hospital. This phase was occurring as the mental health community was moving persons out of the hospital into the community.

In the last ten to 20 years, mental health witnessed an important philosophical shift in development of mental health treatment towards ***community recovery*** as an orientation of

the system. This was the second historical phase, defined, also, by its mental health goal. People with severe mental illnesses are not interested in being good patients as a lifetime goal.

What these people are interested in are the same things everyone is interested in: having a good family and friends, a nice place to live, a job or something meaningful to do, and the ability to manage their own illness, in the same way people manage chronic diseases such as diabetes or asthma.

The characteristics of recovery are the ability to manage the illness and to pursue personally-defined meaningful individual goals.

Recovery does not mean that people are completely cured, just that their quality of life has been improved, that they are able to manage their illness, and that they are able to pursue personally-defined, meaningful goals.

Dr. Drake introduced the third phase of mental health systematic thinking: ***Evidence Based Practice***. This movement, which has also grown over the past ten to 20 years, is not limited solely to the mental health community, but is a worldwide scientific movement toward medical practices and interventions based on empirical evidence, not theory. As professionals try certain interventions in the community, it is clear that some of them are very effective and some do nothing to change the course of a person's life. Some interventions are actually harmful to the client. The evolution of the treatment system should grow from Evidence Based Practice interventions, so that clients receive the most effective, state-of-the-art treatments available. There needs to be a continued shift in money, programs, and training towards interventions that are supported by such empirical research.

Evidence Based Practices—their importance and limitations

Dr. Drake stated that he believed that the Evidence Based Practice movement was fundamentally an issue of education. The medical community is trying to move away from the model where a physician receives his or her training and then practices medicine for many years, using the education he or she received in medical school. According to Dr. Drake, this model has doctors practicing out-of-date medicine for the majority of their careers and not providing good care to their patients.

The educational theory that needs to inform Evidence Based Practices is that the practitioner must be a life-long learner. The empirical evidence about what is effective changes very rapidly. If practitioners ignore their education for ten years, their knowledge base becomes out of date. Dr. Drake said that, although the idea of life-long learning seems overwhelming, it is in fact what makes the work exciting. He spoke about this issue from his 30 years of experience as a clinician during which time he has better understood how to help people. He has seen better outcomes in clients because of his own commitment to life-long learning.

What are the characteristics of Evidence Based Practices?

- **They are standardized treatments.**
- **They are established by controlled research (studies with randomized control group or relatively equivalent comparison groups).**
- **They are procedures based on objective outcome measures. (They are driven by objective outcome data, not a person's values.)**
- **They are based on studies done more than one research group—the evidence is replicable.**
- **They are based on principles that we can test**

Around the Nation, state mental health systems are beginning to adopt a philosophy that promotes such life-long learning; they are developing educational programs for their workforce that provide standardized ongoing training. This training teaches workers what is empirically supported at a particular time, and that they should be life-long learners. The members of the workforce must understand they are in a professional environment where they are expected to upgrade their skills every few years.

Why is Evidence Based Practice so important? Dr. Drake used the history of wound healing to illustrate the point that practitioners don't naturally self-correct their practices. For nearly 150 years battlefield surgeons treated wounds by pouring boiling oil in them in order to cauterize or sterilize them. Now, scientists know that this treatment makes a wound much worse and even causes additional tissue damage. However, the destructive practice continued for 150 years before Napoleon's personal physician tried the gentle healing of wounds—cleansing the wound and trying to keep it clean—which is the practice physicians still use today, 200 years later. The point Dr. Drake made through this example is that it is imperative to look scientifically at outcomes, because practitioners do not naturally self-correct their practices.

Dr. Drake used two other examples of surgical medicine to illustrate other aspects critical to the evolution of Evidence Based Practice medicine. The first was the Carotid Endarterectomy procedure in which surgeons artificially replace the carotid artery to reduce the risk of stroke. When the procedure was first used in the 1960s, the mortality rate varied across hospitals and surgeons from 1% to 40%. Through standardization of procedures, the mortality rate was eventually brought down uniformly to 1%, where it stands today. The concept carries over to the world of mental health. It is imperative to standardize approaches and procedures to Evidence Based Practices. When Evidence Based Practice interventions are modified from location to location and practitioner to practitioner, they don't always achieve the same good outcome.

Effective practices that are strongly supported by evidence. Stakeholders agree that the following should be the cornerstone of all programs for persons with severe mental illness:

- **Medications**
- **Assertive Community Treatment (ACT) —refers to organization of treatment— provide care based on multidisciplinary teams (have specialists on the same team so coherent treatment plan can be presented to client).**
- **Supported employment—provide training and supports clients need to find and hold a job.**
- **Family psychoeducation—provide consistent family education and support. Families and supporters need to learn skills for dealing with mental illness.**

The third illustration Dr. Drake used is the example of prostate disease for which the previous intervention was a very grisly surgical procedure. From observing and what Dr. Drake called "watchful waiting," doctors learned that prostate disease often did not progress much further than the first stage, which did not really require surgery. His point was this: surgeons like to operate, but patients don't necessarily choose surgery if they are given all the information. The same is true for persons with severe mental illness. These consumers must be provided with good information and they must be included in the decision making. Doctors' goals are not always consumers' goals. Consumers differ from professionals and they differ among themselves as far as what choices they will make. Importantly, evidence has shown that if patients are involved in planning and choosing treatment, they have better outcomes.

Values and assumptions underlying the Evidence Based Practices movement

- **People have a right to Evidence Based Practice medicine.**
- **Recovery is the central theme. (Allow people to move on with their lives, rather than just stabilize.)**
- **Consumers and families are partners in the process. (It is important to share information and have consumers sharing in decision-making.)**
- **Services should be based on cultural competence.**
- **Consumer's perspective is**

Even with the promise of Evidence Based Practice, there is still a very large gap between what mental health professionals know and what they do. This is sometimes a result of the limitations of the current evidence, which includes the fact that evidence is constantly evolving and information becomes outdated very quickly. Current evidence also has "boundaries" and often has not been tested for effectiveness of practice for different gender groups or minority groups.

There has been little evidence gathered about effective implementation of many Evidence Based Practice treatments. In answer to this, the mental health community has designed strategies that provide education and planning support to stakeholder groups, which include consumers, families and supporters, practitioners and supervisors, program leaders, and health care authorities.

The strategy is to develop toolkits for training that provide the stakeholder groups with guidelines for implementation, consultation, and longitudinal supervision.

If the system is to truly change, the corrections and mental health systems and all the other stakeholders must come together to as a community to face this issue. Einstein said, "Education is helping people to become life-long learners and to value community goals over personal goals." There is a Swedish maxim that says, "Now we must demonstrate solidarity." To really change the system, we must come together in community and create truly collaborative solutions through consumer-centered dialogue.

Panel Discussion: Science and Policy

Moderator

Vicki Verdeyen
Psychology Administrator
Federal Bureau of Prisons

Panelists

Jack McWay
Chief of Evaluations
Federal Bureau of Prisons

Michael Flaum
Director
Consortium for Mental Health, IA

Michael English
Director
Division of Knowledge
Substance Abuse and Mental Health

Key themes:

- **How should science inform the policy decision-makers about who is treated?**
- **What is known about screening and assessment practices and the treatment modalities that are effective in meeting the needs of those offenders?**
- **Trends in psychoactive**

Key issues raised by the panelists follow.

Dr. Michael Flaum on why academic institutions should not be left out of collaborative efforts and on the growth of telemedicine. It is important that scientists and intellectuals in the country's academic institutions, who are working on cutting edge research in the fields of mental health and corrections, not be left out of collaborative efforts.

According to Dr. Flaum, it is especially important that practitioners advocate for more research opportunities within the prisons. The great advances made in the science of mental health have not been evaluated in the prison settings because of the strict guidelines applied to the use of human subjects. Because of this, scientists have no evidence about what applies in the prison or about what is generalizable to the prison setting.

Dr. Flaum described and introduced telemedicine, which is video link technology that allows the doctor and inmate to conduct a medical session over the television. In essence, the inmate sits in a room and talks to the doctor via television, instead of face-to-face. This allows inmates, who otherwise would not have access to a doctor because of geographical limitations, to have necessary medical consultation. Inmates with mental illness who are incarcerated in rural areas have an especially difficult time accessing clinical psychiatrists and other mental health professionals. Telepsychiatry offers an innovative solution to this problem. Currently, mental health consultation is the most popular use of telemedicine in prisons.

Is telemedicine a good thing? Dr. Flaum said that he didn't honestly know if it is a good thing, but that scientists need to start performing research that would lend support to one position or the other. He stated that it is imperative to begin evaluating and measuring the satisfaction level of people who are using telemedicine.

Jack McWay on the profound needs of the inmate population. Mr. McWay agreed that the alliance between universities and corrections is a very important one. He stated that inmates are a very difficult population to understand. Corrections professionals need to educate the mental health population too about what they've learned in the past working in the prisons. Mr. McWay pointed to the historical pattern of mental health professionals underdiagnosing so that offenders with mental illness could be sent to the criminal justice system where they would receive care. There is a missing link that does not often get mentioned, according to Mr. McWay. This is the problem: even when mental health treatment is received, criminogenic behavior patterns do not always disappear. As many corrections practitioners

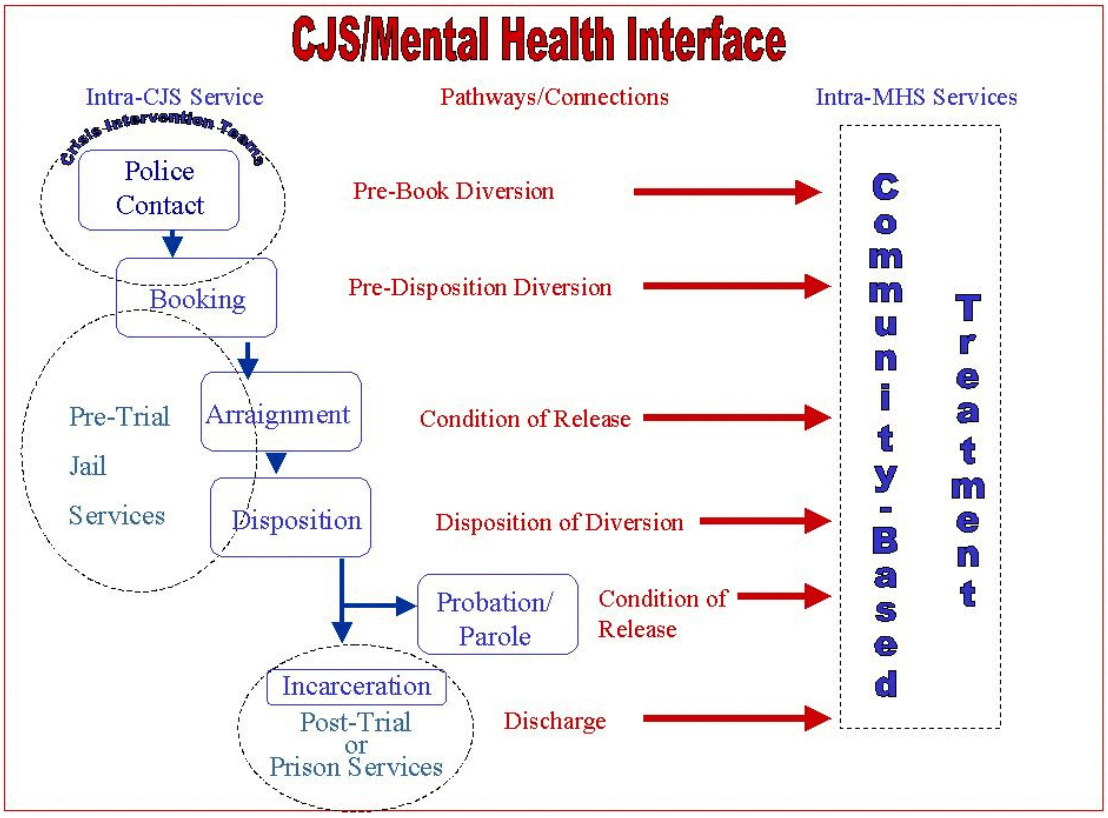
know, the prison population is a "highly malingering one with a propensity to lie"—these characteristics do not simply go away when mental illness is treated.

Mr. McWay stated that the inmate population is also the most neurologically-damaged group of people in the world. Most of them have suffered abuse, head trauma, and many of them have multiple diagnoses. The assessment tools in the prisons need to be standardized and designed to be able to accommodate inmates with multiple diagnoses. Assessment standards in prisons should be of the same quality as those used in the community. As Dr. Osher mentioned, a standardized assessment tool designed to meet the complex needs of the inmate population should be developed and tested so that an inmate's treatment can be based on a reliable diagnosis right from the start.

Michael English on what is working—the importance of continuity of care, which is also a "continuity of opportunity." Mr. English defined the problem by stating that the numbers of persons with mental illness in the criminal justice system have increased dramatically. This increase has:

- Endangered health and safety
- Drained resources for public safety activities
- Created treatment burdens where treatment capacity and competence is lacking

He suggested to conference participants that the key to achieving public safety objectives was to provide treatment and to avoid unnecessary incarceration through a successful working of the criminal justice/mental health interface.



Mr. English noted that treatment for adults does work. He recommended referring to *Mental Health: A Report of the Surgeon General* for details, but he made it clear that the following are all contributing to successful treatment:

- New medications and algorithms
- Assertive Community Treatment (ACT)
- Integrated services for persons with co-occurring mental health and substance abuse disorders
- Supported housing and employment

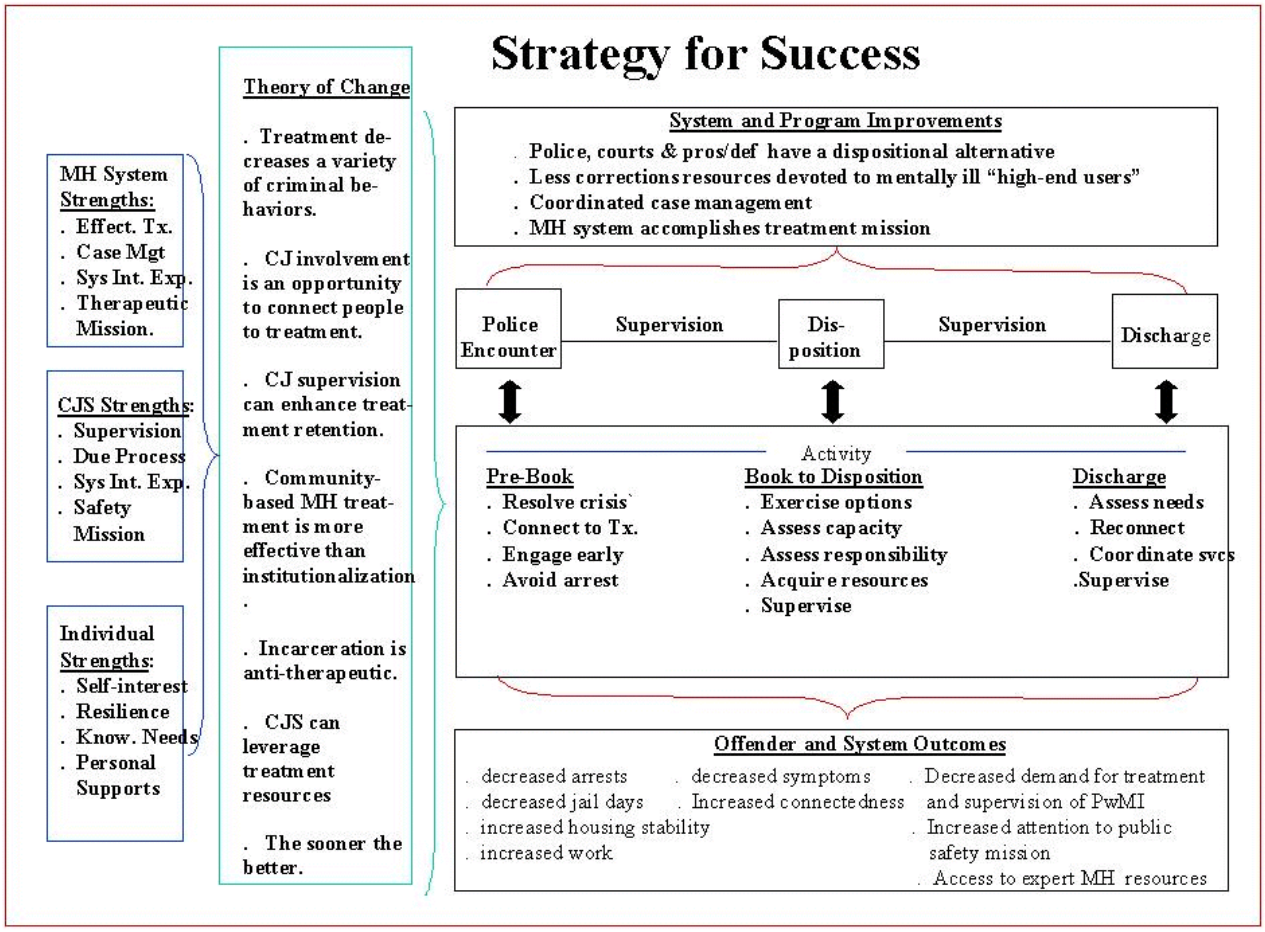
There are also organizational and structural methods that are working, such as:

- Police crisis intervention teams
- Pre and post-booking diversion
- Drug, re-entry, and Mental Health Courts (The evidence base is currently developing for these.)
- Re-entry partnership programs
- Systems of care for children and youth
- Other system integration strategies (for example, the ACCESS model)

Mr. English pointed out that there are partnerships among the criminal justice system and the mental health and substance abuse agencies and the Department of Labor (DOL) that are working. Some of these include:

- Safe Schools/Healthy Students
- Young Offenders Initiative
- Breaking the Cycle
- The Federal Bonding Program
- Criminal Justice and Juvenile Justice Treatment Networks
- Treatment Alternatives for Safer Communities

There are billions of dollars spent on adults in prison and much of it is spent on practices that don't work, according to Mr. English. He stressed that treatment only works if it is embedded in an organizational/structural method that is effective. Institutionalization doesn't work; "therapeutic" peer interactions don't work; doing it alone doesn't work; collaboration, integration, and diversion without quality services doesn't work. The following diagram shows a potential strategy for successful collaboration during the continuum of care.


Strategy for Success
MH System Strengths:
. Effect. Tx.
. Case Mgt
. Sys Int. Exp.
. Therapeutic Mission.
CJS Strengths:
. Supervision
. Due Process
. Sys Int. Exp.
. Safety Mission
Individual Strengths:
. Self-interest
. Resilience
. Know. Needs
. Personal Supports
Theory of Change
. Treatment decreases a variety of criminal behaviors.
. CJ involvement is an opportunity to connect people to treatment.
. CJ supervision can enhance treatment retention.
. Community-based MH treatment is more effective than institutionalization.
. Incarceration is anti-therapeutic.
. CJS can leverage treatment resources
. The sooner the better.
System and Program Improvements
. Police, courts & pros/def have a dispositional alternative
. Less corrections resources devoted to mentally ill "high-end users"
. Coordinated case management
. MH system accomplishes treatment mission
Police Encounter
Supervision
Dis-position
Supervision
Discharge
Activity
Pre-Book
. Resolve crisis`
. Connect to Tx.
. Engage early
. Avoid arrest
Book to Disposition
. Exercise options
. Assess capacity
. Assess responsibility
. Acquire resources
. Supervise
Discharge
. Assess needs
. Reconnect
. Coordinate svcs
.Supervise
Offender and System Outcomes
. decreased arrests
. decreased jail days
. increased housing stability
. increased work
. decreased symptoms
. Increased connectedness
. Decreased demand for treatment and supervision of PwMI
. Increased attention to public safety mission
. Access to expert MH resources

Panel Presentation: Corrections Mental Health Directors

Key issues raised by the panelists follow.

Moderator

Tom Powell

Gary Field
Administrator for Counseling and Treatment Services
Department of Corrections, OR

Panelists

Deborah Nixon-Hughes
Chief
Bureau of Mental Health Services, OH

Scott Haas
Chief of Psychiatric Services
Department of Corrections, KY

Tom Powell
Clinical Director
Department of Corrections, VT

Key themes:

- **Changes in severity of illness of those coming into prison**
- **To what extent is diversion possible?**
- **Prioritization of services with limited research**
- **Definition corrections mental health services broadly and narrowly**
- **Creation of transitional and aftercare programs**
- **Line item funding**

Tom Powell on the responsibility of mental health practitioners. Mr. Powell told conference participants that the state corrections mental health directors met earlier this year in Atlanta and that this panel discussion was one of the outcomes of that meeting. When speaking of corrections expanding role in the management of persons with mental illness, he said, "There are many reasons to do what we do, but the best reason is that it's the right thing to do."

Mr. Powell mentioned the legal framework behind treating inmates with mental illness. In the mid 1970s, it was ruled that inmates have the right to health care. Other court decisions have mandated parity between mental health and regular health care for inmates.

Statistics show that between 7% and 12% or one-quarter to one third of the prison population is in need of services—some profoundly so. Mr. Powell urged conference participants to realize that the negative mental health effects of prison may also be extremely debilitating. The physical design of prisons—concrete walls, bright lights, and constant loud noises—married with the prevalence of dangerous, predatory behavior creates and perpetuates a sense of helplessness and hopelessness among the population.

Mr. Powell suggested that the following be areas of focus in the future:

- Create better ways to assess what corrections professionals are seeing.
- Design unique methods to address elders, women, and juvenile offenders with mental illness.
- Understand mental health in corrections through a public health lens.

Gary Field on the challenges facing corrections. Mr. Field suggested that corrections doesn't know enough about the population it is working with. He reiterated Mr. Powell's recommendation for the development of a standardized assessment tool, stating that practitioners need to be able to:

- Diagnose mental illness by level and severity.
- Develop a mental health classification system for offenders.
- Identify exact numbers of mentally ill in facilities.
- Communicate and profile legal hot spots around the country.

The largest philosophical and public policy issue facing corrections is the question of whether to allocate resources towards building treatment programs inside prisons or to advocate more strongly for diversion from the criminal justice system, using avenues such as the mental health court model. Mr. Fields believes that diversion from prison is the much more desirable option. Another key issue from the public policy point of view is that there must be a better way to ensure that the resources follow the population when offenders are transitioning from the institution to the community.

Scott Haas on the need for collaboration and the responsibilities of corrections mental health directors. Mr. Haas stressed that the need for community follow up of care for inmates is critical. Agencies must collaborate to overcome the continuity of care barriers, such as statutes of limitations and access to medication. Mr. Haas suggested that the collaboration must be documented with a memorandum of agreement that delineates each organization's specific responsibilities so that all can be held accountable.

Mr. Haas agreed with Mr. Powell's assessment of the negative effects of institutionalization. Generally the symptoms of offenders' emotional or mental disorders are exaggerated within the institution, because of the criminal culture that permeates the setting. This culture engenders distrust of authority figures, perpetuates emotional and physical trauma and supports—rather than discourages—inmates' tendencies towards manipulative and violent behavior.

In creating a transitional plan, corrections and mental health agencies must work together to create a plan that addresses the concerns of both parties. They must work together to make sure that mental health resources are available to the inmate in transition and that his or her violence issues have been adequately addressed.

A primary responsibility of the corrections mental health directors is to continue to share information with one another, with their staff members, and with their superiors in the chain of command. To answer this need, they are forming a National organization of corrections mental health directors.

Some information-sharing in the future could include:

- Informing treatment providers about confidentiality issues within corrections.
- Teaching staff strategies for interacting with administrators.
- Reviewing and monitoring innovative treatment approaches in practice around the country (for example, telemedicine).

Deborah Nixon-Hughes on pulling together stakeholders and garnering necessary resources. Ms. Nixon-Hughes noted that pulling together state stakeholders is an important first step towards collaboration. Directors must promote the idea that there *are no colliding philosophies*—providing good mental health in prisons is also sound management. Effective mental health treatment provides positive operational outcomes such as decreases in attacks on staff and decreases in harassment of other inmates. Treatment of mental health can no longer be an afterthought; it must be an integral part of the inmates' stay in prison and of the institution's operational, managerial planning and budgeting.

Research and funding are the key to developing innovative and effective mental health systems. In setting up mental health services, directors need to include auditing and evaluative tools so that they can look realistically at statistical outcomes.

Ms. Nixon-Hughes offered the following thoughts and guidelines:

- Set up an Advisory Committee to guide transitional planning for inmates with mental illness who are transitioning in and out of prison.
- Promote line item funding for mental health; this kind of funding can no longer be a sidebar or an afterthought. It is an essential aspect of successfully managing inmates in prison.
- Advocate to change Medicaid and Social Security guidelines—it does not make much sense to release inmates without money and without health care.
- Educate yourself and your staff about subsidized housing guidelines, which vary state to state. In some states, felons are ineligible for subsidized housing.
- Promote Assertive Community Treatment (ACT).
- Attempt to speak the same language and to engage in conversations about understanding.
- Advocate for additional funding for psychotropic medication. Medication use has doubled over the past two years and funding that would allow institutions to have open formularies does not exist. If an institution is unable to fund an open formulary, directors should look into the option of algorithms.

Lunch Presentation—*The Honorable Edward M. Kennedy*

Speaker

The Honorable Edward M. Kennedy
United States Senator, MA

Senator Kennedy addressed the conference via video, thanking all participants for attending and contributing to the event. He emphasized the importance of the issue and encouraged states to continue to build on the foundation that they were developing during the conference. He offered his support for addressing the serious issue of mental illness in our Nation's prisons.

Panel Discussion: Effective Collaborations

Moderator

Stephen Amos
Executive Director
Maryland Governor's Office of Crime Control and Prevention

Panelists

Dee Kifowit
Director
Texas Council on Offenders with Mental Impairments

Victoria Roberts
Administrator for the Community Protection Unit
Department of Corrections, WA

Tom Barrett
Director
Mental Health Services, CO

Marylou Sudders
Commissioner
Department of Mental Health, MA

Richard Cevasco
Assistant Director
Health Services Division of Operations

Key themes:

- **State programs in which corrections and mental health agencies are effectively working together to identify, treat, and monitor offenders with mental illness**
- **Programs that have overcome the barriers to**

Stephen Amos introduced the idea that it often takes a watershed event, sometimes a tragedy, to bring about action that secures the necessary resources to make significant progress. Key issues raised by the panelists follow.

Tom Barrett on Colorado's Legislative Task Force on People with Mental Illness. The task force established in Colorado identifies problems and proposes legislation to begin to address the problems of persons with mental illness in the criminal justice system. The task force is made up of 24 important stakeholders, including persons that represent the following agencies and perspectives:

- Criminal justice
- Parole board
- Law enforcement
- Child welfare agencies
- State hospitals
- Education
- Attorney General's office
- Licensed clinical professionals
- Consumer family members

There has been some very good cooperative work accomplished by the task force, including advocacy for legislation. Three bills were passed last year and the state is in the process of completing the work outlined in these bills. The issues addressed in these bills are:

- Sentencing alternatives
- Changes in involuntary commitment statutes
- Community-based alternatives to incarceration

The bills also pointed out some weaknesses in the current system that had built up over the years, such as safety issues, which demanded a shift in resources.

Because of the task force, Colorado has been fairly effective at getting legislation passed that supports initiatives for offenders with mental illness, including legislation for a standardized assessment instrument to be used across the state. However, Mr. Barrett pointed out that there will be no real change in the trend, unless the community provides better services up front that will prevent people from getting into the system in the first place.

Richard Cevasco on New Jersey's Internal Treatment Team. New Jersey has four facilities that house offenders with mental illness who have specialized housing needs. If inmates are on one of these units, they are required to meet with the treatment team regularly to discuss the inmate's progress. The correctional officer is always part of the team and will offer a valuable perspective about the inmate cooperation and level of danger. This information is vital to the treatment, especially on New Jersey's stabilization units, where the goal is to get inmates out of their cells and to treatment other programs that have been prescribed.

The defining watershed event in New Jersey that freed up resources was the settlement of a class action lawsuit, which provided an infusion of money into the system to allow the state to provide better mental health services in the prisons.

The result of this lawsuit, Mr. Cevasco said, is that a cognitive shift was demanded for corrections employees—the attitude could no longer be "lock 'em up, throw away the key;" instead, an investment in mental health was required and expected. The paradigm shift had to come from the top down. Leaders had to promote the idea that corrections staff really were going to change the way they treated mentally ill inmates, and that there would be negative consequences for those who resisted this change.

Marylou Sudders on Massachusetts' Department of Corrections/Department of Mental Health (DOC/DMH) Interagency Work Group. The Interagency Work Group addressed has addressed the following issues using the strategies outlined below.

To improve and standardize the process of transitioning patients from the state hospital to the mental health agency, the work group:

- Met regularly to review the transition of individual patients from the hospital to the mental health agency.
- Established a common language to clarify processes and roles.
- Established a protocol for transition of both the short term (in for observation) and long term (committed) patients.

To better share critical information about patients in order to improve the quality of care and service delivery, the work group:

- Sought to share the maximum amount of information permitted by the statute.
- Established a procedure to identify and share information about patients who have received DOC/DMH mental health services.
- Considered strategies for releasing information pursuant to specific statutes if a patient refuses to release information.

To coordinate planning among agencies responsible for providing services to the mentally ill, the work group:

- Jointly identified target agencies.
- Jointly contacted target agencies to develop and clarify protocols for working together.
- Worked with Massachusetts Health to clarify the application process and discuss possible revisions to it.
- Established procedures, through the DOC, to transport inmates leaving facilities who are in need of assistance.

To facilitate DMH eligibility determination and release planning for potential DMH clients in DOC facilities, the work group:

- Jointly reviewed DMH state-wide eligibility determination protocol for compatibility with release planning for incarcerated individuals.
- Established procedures to provide DMH with accurate and timely sentencing release eligibility dates.
- Reviewed internal compliance with the current DMH eligibility application process.
- Enhanced DMH procedures that advise DOC caretakers of alternate resources for mentally ill inmates who do not qualify for DMH services.

To facilitate joint DOC/DMH needs for training staff on the management of the mentally ill offender, the work group:

- Developed a needs assessment.
- Explored funding sources.
- Explored and created inter-disciplinary cross-training.
- Created a joint training plan.

The focus on offenders with mental illness in the state of Massachusetts grew out of a high-profile suicide within the prison system. All progress in Massachusetts that grew out of this incident was not enacted through legislation or lawsuit, but through the design and enforcement of new, targeted policy. The policy, however, would not have worked on its own without strong leadership. The increased focus on mental illness in the prisons was also the result of a change in leadership in both the DOC and the Mental Health agencies. Both new leaders were committed to working together to solve the problems associated with the mentally ill offender in the prisons. According to Ms. Sudder, subtle barriers continue to exist that need to be studied and dealt with in an innovative, collaborative fashion.

Dee Kifowit on the Texas Council on Offenders with Mental Impairments. The mission of the Texas Council is to provide a formal structure for criminal justice, health, human service, and other related organizations in which to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. These offenders include those with serious mental illness, mental retardation, terminal or serious medical conditions, physical disabilities, and those who are elderly. The Council, as outlined in the statute, is made up of 21 agencies and organizations that have an interest in offenders with special needs. In addition, the Governor appoints nine at large members who serve staggered six-year terms. These members have 11 legislative directives that range from, "Determine the status of offenders with special needs in the state criminal justice system" to "Develop and implement programs to demonstrate a cooperative program to identify, evaluate, and manage outside of incarceration offenders with special needs."

This state agency, which was created for the sole purpose of creating and monitoring continuity of care for offenders with mental illness in Texas, provides a centralized voice for gathering resources, attracting attention, and organizing collaboration around the issue of persons with mental illness in the criminal justice system. Ms. Kifowit stated that there are no laws in Texas that preclude sharing of information, which has made the road to collaboration in her state a relatively smooth one. "Miracles can happen," she said, "When we share the resources and the power." She suggested that it is also possible to come to agreement among the administrators to deal with information-sharing in innovative ways.

Ms. Kifowit mentioned the importance of working on mental health plans in prisons before the inmate is released. In Texas, through detailed planning and collaboration between corrections, mental health, and local benefits agencies, inmates are getting their Medicaid cards in hand 90 days before release.

Victoria Roberts on Washington State's Dangerously Mentally Ill Offender Legislation.

The Dangerously Mentally Ill Offender Legislation was enacted into law during the 1999 session of the Washington State Legislature. It is intended to help provide improved public safety and additional mental health treatment for the dangerously mentally ill and chemically dependent mentally ill offenders. The law became effective March 15, 2000, with the following provisions:

- Requires the identification of dangerously mentally ill offenders being released from DOC facilities into the community.
- Requires SSHS and DOC to enter into a written agreement, or draft rules, to expedite financial and medical eligibility determination for this type of offender.
- Requires pre-release planning, including possible civil commitment evaluation by inter-agency teams. The teams must include representatives from DSHS, DOC, the Regional Support Networks (RSN), and mental health providers.
- Provides additional funds for services to these offenders at approximately $10,000 per person annually for up to five years.
- Requires an impact study by the Washington State Institute for Public Policy and the Washington Institute for Mental Illness Research and Training.

General discussion for future initiatives and planning:

- **Who are non-traditional partners?** The system tends to ignore victims and their role in the process. Future plans should include an increase in the involvement of victims groups and the faith community. Victims should be part of the process. Victims, communities, and traditional agencies should get together first and begin speaking the same language by creating written agreements.
- **Technology is important to effective information-sharing.** In Texas, computer systems were designed so that the corrections systems can cross-reference with mental health systems.
- **It is important to avoid duplicating services in the interest of cost.**
- **An effective, important way to share information is through the signed consent form.**
- **Money should follow the mentally ill offender with targeted funds.**
- **Agencies should attempt to provide more services at the front end.** Divert more people up front to receive Medicaid and lobby the Federal government about access to Federal entitlements. There does exist a range of entitlements, however, in each state.
- **Increase communication with veteran's agencies.** Some states screen inmates when they enter the system to see whether or not they are veterans.
- **Housing is a vital piece of continued care.** Twenty-four hours after release, an offender can be defined as homeless. States need to work with Federal partners to develop creative initiatives for housing that work around the current restrictive definitions of housing.
- **What is the role of the offender?** Panelists agreed that engaging the offender is critical to the process. They must be involved in the planning process; it is possible to engage the offender while he or she is in the corrections system through intensive case management.
- **What are some remaining barriers?** Panelists cited lack of parity in resources for mental health issues and a lack of residential programs as barriers to securing quality treatment for all mentally ill offenders.

  States need to develop methods and tools that allow a uniform assessment of how many mentally ill they have in prison.

  States need to explore the option of telepsychiatry, especially in local jails so you don't have to transport people to receive services.

Panel Presentation: Council of State Governments (CSG)

Description of the Council of State Governments (CSG):

The CSG—a non-profit, nonpartisan organization—has partnered with the Police Executive Research Forum (PERF), Pretrial Services Resource Center (PSRC), the Association of State Correctional Administrators (ASCA), and the National Association of State Mental Health Program Directors (NASMHPD). Each organization coordinates an advisory group of practitioners—local law enforcement, courts, corrections, and the mental health community—charged with developing detailed, bipartisan recommendations, which would improve the criminal justice system's response to individuals with mental illness. Furthermore, each advisory group is identifying elements of best practices across the United States that could be

Moderator

Thomas Coughlin, III
Senior Counselor
Criminal Justice Institute

Panelists

William Sondervan
Commissioner
Division of Corrections, MD

James Stone
Commissioner
Office of Mental Health, NY

Charles Moose
Chief of Police
Montgomery County Police Department, MD

James Gregart
Prosecuting Attorney
Kalamazoo County, MI

Mike Lawlor
State Representative
Co-Chair, Joint Judiciary Committee, CT

Robert Thompson
State Senator

William Sondervan on the role of corrections.

The CSG is important because it brought all the stakeholders together, so that they could be sitting around the table, collaborating and discussing the many complex aspects of the issue of the mentally ill offender in the criminal justice system. The Council was divided up into different tracks corresponding to specific disciplines. Each group defined a set of recommendations for the practitioners they represented.

Corrections Track
Coordinator:
Association of State Correctional Administrators.
Project Director:
George Vose

Mr. Sondervan participated in the Corrections Track, which was coordinated by the Association of State Correctional Administrators.

The Corrections Track surveyed promising practices and talked about why this issue is important now. Over the past 20 years, the majority of the money in corrections went towards bricks and mortar; the focus was not on

providing treatment, but on building facilities. Currently the number of inmates coming into the system is slowing down, which means that corrections has an opportunity to change their mission from one that appears to be warehousing into one that includes the capacity to provide effective treatment.

Some of the complexities that correctional administrators must deal with, day in and day out, are offender illness, age, and substance abuse. The overcrowding and understaffing of facilities perpetuate idleness among the inmates. Mr. Sondervan's facilities in Maryland are short 600 correctional officers because of a major problem in recruiting for jobs that offer low pay and stressful work conditions. Another roadblock is that the corrections system lags behind society in the use of technology.

The goals established by the corrections track were:

- Develop protocols across the criminal justice system.
- Enact consensus-driven recommendations.
- Highlight with promising practices.
- Increase the credibility of corrections commitment to collaboration by working with CSG.
- Develop and sustain partnerships and leverage shared resources.

Jim Stone on the role of mental health agencies. Mr. Stone named the mental health stakeholders who are interested in the issue and said that CSG allows them to educate each other and to come together in consensus so that they can speak with one voice. Some of the issues the mental health track addressed include:

- The role of the media.
- The cost of new drugs.
- Prevention and public health as viable perspectives.
- Evidence Based Practice.

Mental Health Track
Coordinator: National Association of State Mental Health Program Directors.
Project Director: Bill Emmet

Chief Charles Moose on the role of law enforcement. Chief Moose urged conference participants to understand the importance of including police officers in the discussion in their states. Without inclusion, law enforcement begins to point fingers at other agencies such as mental health services or the criminal justice system. He bemoaned the fact that a tremendous amount of potential for improvement turns into finger-pointing. The police want to do a better job; they often just don't know how to do it. He asked state planners to please include law enforcement in planning initiatives and to help them to better understand their role in the administration of services.

Law Enforcement Track
Coordinator: Police Executive Research Forum.
Project Director: Melissa Reuland (202) 466-7820

Courts Track
Coordinator: Pretrial Services Resource Center.
Project Director: John Clark
(202) 638-3070

James Gregart offered an attorney's perspective. Mr. Gregart, who served in the past as a deputy sheriff, has a practical understanding of the criminal justice system. He maintained that public perception forms public policy and that previous policies were established from a Nationwide response to mental illness as it was presented in the media. According to Mr. Gregart, it is the responsibility of groups like CSG to develop models that will create consensus among previously disparate groups. Organizations must build trust and relationships and educate one another. Groups must work to get

ahead of what appears to be a crisis; they are called not only to solve the current problem but also to anticipate and head off future problems.

Mike Lawlor and Robert Thompson on the role of legislators and policy makers. Representative Lawlor emphasized the practicality of the CSG's non-partisan status and its attempts to bring states together across ideologies over an issue that is potentially politically "radioactive." The problem is not solely philosophical, but it is also practical, and legislators and policy makers must make an effort to reach across the political divide to include all stakeholders.

Senator Thompson also commented on the organization of CSG; its horizontal structure allows input from all three branches of government, which is extremely wise when exploring policy options. According to him, there is nothing worse than a legislative fix for a problem, when that fix is based on perception rather than fact. The CSG process is as much part of the product as the product itself. The group could be valuable in offering input for legislative initiatives, administrative guidance to organizations, and options for guiding public safety. Eventually, Senator Lawlor feels that some issues related to offenders with mental illness in prisons will eventually become civil rights issues. Organizations like CSG offer stakeholders the opportunity to solve problems and plan for the future by working together. He suggested that if you are not part of the solution, then you are part of the problem.

Panel Discussion: Assessing Risk upon Re-entry

Moderator

Richard Stalder
Secretary
Department of Corrections, LA

Panelists

Linda Dillon
Chief
Division of Program Services
Department of Corrections, IL

Mario Paparozzi
Chair
State Parole Board, NJ

Barry Kast
Administrator
Mental Health and Developmental Disability Services Division, OR

Key themes:

- **What is the liability exposure to corrections and mental health agencies in assessing risk?**
- **What responsibility does either agency have on victim and community notification?**
- **What are effective risk assessment instruments—what tools do we use and how good are we at it?**
- **Show we recommit to**

Key issues raised by the panelists follow.

Linda Dillon on the importance of offender responsibility. Ms. Dillon asserted that an integral piece of assessment is making sure that offenders understand what they need.

If the treatment program is important to us, but not the offender, then it will not work. Practitioners must ensure that offenders are prepared to take responsibility. The mental health services within the prison must prepare inmates for release and re-entry, and this preparation must begin from the day they enter the system.

Barry Kast on getting better information so that practitioners are better able to predict risk. Mr. Kast stated that the ability to predict risk is directly related to the extent that the system can get information about a person and his or her treatment history.

In an overburdened system with barriers to information-sharing, practitioners incorrectly assess risk or fail to predict violence because they are missing vital information. Currently mental health practitioners deny predictability; but is there any research that shows that we can quantify risk?

Risk assessment tools are certainly improving—Mr. Kast cited the MacArthur study as providing valuable information, including the statistic that 80% of a diagnosis is based on obtaining a good history. Mental health agencies must do a better job of clarifying the difference between prediction and assessment, and they must take a stronger stand on assessment.

In Oregon, the system is promoting treatment, good case management, and a managed care programs within the system. The data gathered from that process is the data that produces risk assessment for that offender. The system must try to determine when an offender will fail. It cannot leave responsibility up to the offender.

Mario Paparozzi on the importance of using the appropriate protocol and on assessing community standards. Mr. Paparozzi pointed out that there are differences in treatment and assessment tools used across

the state. It is good public safety policy to pursue state-of-the-art risk assessment. When agencies use the appropriate protocol, they guess right more often than not.

Mr. Paparozzi stated that it is imperative not to limit the assessment to individual factors, but that assessment factors should also include community factors. Agencies should consider the environment to which the offender is returning. Is unemployment high there, or not? Are there treatment programs there, or not?

Looking at the person in the context of his or her environment is absolutely critical. For the time being, is providing an individually-tailored treatment plan mostly a public safety issue or an issue of individual productivity? Mental health practitioners must also accept the role of protecting public safety in assessing risk. It is also imperative to keep the victims, who are a very focused advocacy group, involved in the assessment process.

General comments about medication and risk assessment, women, and static versus dynamic assessment instruments:

- **It was agreed that the parole board must monitor an offender's medication**.
- **Medicine is often hard to get on the street, especially if the offender is indigent.**
- **There exists the irony of mandating medication and services that are not available in the community.** Often the system is more responsible for creating failure than the offender is.
- **Most parole boards currently do not have a special board to deal with issues specific to women.** It was suggested that they be treated as a specialized caseload.
- **Static factor instruments**, which were introduced in the 1970s and were validated locally, would not tell practitioners about criminogenic factors. **Dynamic factor instruments** are known to predict just as effectively and allow the element of subjective override.

Day three
July 20, 2001

Theme

Re-entry of offenders with mental illness back into the community

Panel Discussion: Re-entry that Works

Moderator

Renata Henry
Director
Division of Alcoholism, Drug Abuse, and

Panelists

Richard Purvis
Director
Division of Mental Health
Department of Corrections, KY

Jim Holwager
Clinical Director for Mental Health
Department of Corrections, MD

Reverend Peter Young
Volunteer CEO
Peter Young Housing Industries and
Development, NY

Key themes:

- **What are the roles of the mental health and corrections agencies in transitioning offenders from institutions to community settings?**
- **Pre-discharge planning**
- **Ensuring the offender will have treatment and medications, if necessary**
- **Organizing for housing**

Key issues raised by the panelists follow.

Renata Henry introduced the stakeholders in effective re-entry planning. Ms. Henry said that the following stakeholders should be involved in the re-entry process:

- Offender
- Local state alcohol/drug agency
- Treatment providers
- Medicaid
- Victims groups
- Elected officials
- Department of Labor
- Communities themselves
- Faith-based, recreational organizations

Ms. Henry outlined the responsibility of stakeholders as follows:

- They should be concerned about policy.
- They should define procedures.
- They should make funding decisions.
- They should collaborate around practice.
- They should establish non-discrimination policies.
- They should train across various systems.

She stated that agreements and role definitions must be documented down. The collaborative group must decide who will be responsible for the different parts of discharge planning. They must set milestones and establish deadlines and organize for monitored medication. All of these agreements should be documented. An important part of successful re-entry is the Treatment Status Report. This document defines how treatment or lack of treatment will be communicated back to corrections.

Jim Holwager on the tenets of pre-discharge planning, and on the importance of medication, monitoring, and integrated treatment systems for co-occurring disorders. Mr. Holwager introduced the following as the tenets of pre-discharge planning:

- Discharge planning begins at intake.
- Treatment starts with the right diagnosis.
- Develop an aftercare plan.

- Help the inmate take accountability for his or her life and plan. Institutionalization is based on making people feel like they're helpless and not held accountable for their actions, so taking responsibility requires a paradigm shift for the inmate.
- Treat the inmates' criminality when you treat their mental illness.
- "Be crazy. "
  Be excited about what you can do. Providers are coming into the prisons and corrections workers are selling a product that's not too pretty. Corrections staff can't "say no" to who it is they're treating; they can't "say no" to letting these people out of jail.
- Don't stop when you've handed off. Follow up, keep working. The goals are to reduce recidivism and to keep people safe.

Corrections and mental health practitioners must make sure that people are on the right medication. This is especially important with the advent of extremely effective, and well-tolerated anti-psychotic medication. It is an economic necessity for prisons to have a formulary. It is important that practitioners take the time to know what they're talking about when they are handing out medication and connecting people back into the community.

Part of discharge planning is to give individuals the skills they need, so that they are empowered to implement their treatment plan. You need to start from where they are, not where you are. You must stress the importance of medication when working with the mentally ill and set up panels that oversee and monitor the use of medications.

Jim Holwager mentioned that persons with co-occurring disorders often self-medicate. Practitioners should define what integrated treatment is and see who in their community offers integrated treatment for these types of offenders as they are being released. Mental health workers should be trained to understand how several disorders play off one another and understand the concept of truly integrated services. The question is: How do you pull together disparate systems and provide treatment using a truly integrated model?

Peter Young on his faith-based training center, Peter Young Housing Industries and Development in Albany, New York that provides treatment, housing, and employment and on the importance of networking. Father Peter Young uses the acronym HIT to describe his program that provides housing, industry, and treatment. Ninety-seven percent of his staff are ex-offenders. People who come through his program will be trained to get a job in hospitality, retail, culinary, maintenance, or computers. The organization offers:

- Substance-free, safe, and inexpensive housing
- Industries that will guarantee a job
- Treatment for their illnesses, including required participation in a DSM-IV assessment

Frequently, Father Young said that it's a battle over the Medicaid card; it appears to him that the system discriminates against persons who are most the disabled. It is imperative that organizations network with collaborating agencies.

General discussion for future initiatives and planning:

- **Take advantage of the substance abuse side of drug court.** They provide a case manager that can help navigate the system and apply its parts to the needs of an individual.
- **How much do you involve family and friends?** Recovery is significantly tied to whether or not one has relationships; however, many of these offenders have alienated their family and friends by causing them a lot of pain and disappointment. At the same time, often the offender's family is dysfunctional and is not the healthiest community for

the offender to re-enter. It is a struggle to try to find a positive social network for offenders.

- **What happens if you don't plan?** Offenders recidivate. People get hurt if you don't plan.
- **Think strategically when you go to legislatures, requesting funds.** Speak in legislative language; use terms such as "litigation" and "responsibility towards constituency."

Panel Discussion: Accessing Federal Entitlements

Moderator

Chris Koyanagi
Policy Director
Bazelon Center for Mental Health Law

Panelists

Steve Richardson
Specialist
Regional Public Affairs
Social Security Administration

Ron Preston
Assistant Regional Administrator
Division of Medicaid and State Operations,
Center for Medicare and Medicaid Services (formerly HCFA)

Marian Bland
Director
Shelter Care Plus Housing Program
Department of Health, MD

The panelists discussed how offenders access Federal disability aid and what must be present in order for them to meet the disability requirement. The document, "For People with Serious Mental Illnesses: Finding the Key to Successful Transition from Jail to Community—An Explanation of Federal Medicaid and Disability Program Rules" was recommended as an excellent resource. The document is published by the Bazelon Center for Mental Health Law in Washington, D.C.

Key issues raised by the panelists follow.

Steve Richardson on Social Security Disability Insurance.

Mr. Richardson stressed the fact that all prison facilities need to develop a relationship with their local Social Security office.

Social Security Disability is a needs based program that is paid monthly. If an offender has been in prison for less than 12 months, he or she can expect payment about 10 days after requesting reinstatement.

Often, released offenders are told in prison that they will receive a payment on the day they get out. This is not true.

Key themes:

- **Policies and regulations that involve reinstating prisoners with their Federal benefits**
- **Accessing Federal funds that can be used to assist in transitioning offenders back into the community**
- **How to make organization of Federal funding part of pre-release planning**
- **How will these benefits assist in establishing a continuum of care for offenders?**
- **What do different benefits provide?**
- **How pre-release planning**

Ron Preston on Medicaid.

Mr. Preston stated that the health care system is actually a judicial system that decides who is most entitled to benefits. He recommended that state agencies start by developing a relationship with their own state Medicaid office.

Marian Bland on Maryland's Shelter Plus Care Housing Program.

Maryland's Shelter Plus Care Housing Program began in 1992. It serves consumers with serious mental illness and/or co-occurring disorders. It provides:

- Case management
- Psychiatric services
- Housing and entitlements
- Local advisory boards

Maryland secured the funding through HUD McKinney-Vento funding for permanent housing. Shelter Plus Care provides rental assistance through tenant, sponsor, project, and SRO-based models. Supportive housing

provides funding for leasing or purchasing housing and may include funding for supportive services.

Maryland Shelter Plus Care Accomplishments:

95% of participants housed have remained in housing.

91% of participants had some source of income within a year.

Only 3.9% of the participants returned to the detention center, only 1% were hospitalized for psychiatric reasons, and only 1% returned to homelessness.

The program has served a total of 407 single adults, 186

In order for a person to be eligible for HUD McKinney Vento funding, the participant must be homeless and disabled. The definition of "homeless" includes individuals who are being discharged from an institution where they have resided for more than 30 days, and who are without housing, resources, and support.

In 1995, the Mental Hygiene Administration (MHA) submitted a consolidated state application to HUD. MHA was awarded $5.5 million to provide tenant- and sponsor-based rental assistance. Rental assistance is provided in Maryland to 22 of 23 counties.

In order to qualify for Maryland's Shelter Plus Care Housing Program, an individual must:

- Be homeless
- Have a serious mental illness
- Be coming out of a detention center
- Be in the community on probation or parole
- Meet income requirements
- Develop a service plan
- Participate in supportive services

The case manager plays a vital role in managing the program. He or she performs the following duties:

- Identifies and screens applicants for the program.
- Develops a service plan with participants and assists participants in linking to services.
- Helps participants through the application process and helps them find housing, negotiate lease agreements with landlords, and obtain furniture.
- Provides case management services and resolves crisis management situations.
- Assists with budgeting.
- Helps participant apply for entitlements such as SSI, SSDI, Medicare, and TANF.
- Monitors involvement in supportive services and forwards to MHA monthly.